DETOXIFICATION OF HABITUAL DRUNKEN OFFENDERS

A Thesis presented by

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CONTENTS

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SUMMARY

1. Alcoholism is a major social and medical problem in Scotland and convictions for drunkenness offences increase each year; there is evidence that most drunken offenders are alcoholics. A minority of vagrant alcoholics are known to medical sources and penal management of drunken offenders has resulted in the offender repeatedly passing through courts and prison, receiving little if no help with his alcoholism. Legislation in England and Wales has been enacted, but not implemented, to remove the penalty of imprisonment for drunk and disorderly behaviour, and a Home Office Working Party has recommended the establishment of detoxification centres to deal with public drunkenness.

2. The aims of the project on which this thesis is based were to assess the feasibility and effect of adding a detoxification service to a Regional Poisoning Treatment Centre, and to a psychiatric hospital; and to evaluate the effectiveness of this detoxification, assessment and referral service for socially deteriorated alcoholics.

3. The cohort consisted of 100 Edinburgh males who were alcoholics, were receiving no current treatment for alcoholism and who had a history of convictions for drunkenness offences. The cohort were randomly allocated to proband and control groups, the latter receiving no treatment. The

probands were able to use the detoxification facility when intoxicated or having alcohol withdrawal symptoms, and police agreed to waive their right to prosecute a proband if found drunk and incapable, instead to take him to the detoxification centre. This experimental period lasted one year.

4. The characteristics of the subjects are described and compared with the findings in other studies, the individuals being found to have a high degree of medical, psychological and social pathology.

5. The detoxification programme is described - the management of withdrawal symptoms, medical investigations and methods of assessment and referral. Difficulties were encountered when the project was located in the Regional Poisoning Treatment Centre and these are described and discussed together with a review of the literature on attitudes of doctors and nurses towards alcoholics. Relatively few problems were encountered after transfer to the psychiatric hospital.

Data is presented on admissions for detoxification, and medical morbidity over and above detoxification and withdrawal was recorded in about 50% of the admissions. Eleven of the cohort died in a 2-year period, twice the rate for the general population.

6. Evaluation of the results showed that during the experimental year the change from the penal to the medical

system was effective with a greatly diminished penal record among the proband group, while the controls continued to be prosecuted and imprisoned at the same rate as in the pre-experimental year. The assessment and referral service was likewise effective, the number of admissions to and time spent by the proband group in psychiatric hospitals and rehabilitative hostels being greatly increased with respect to both their own pre-experimental year and when compared with the controls.

Eighty-five percent of the cohort were followed up one year after enrolment and a questionnaire assessment showed the probands to have improved with respect to their accommodation and their subjective impression of the quality of their lives. It is probable that there had been an improvement in their physical health. The drinking habits of the probands had improved but not in comparison with the control group.

7. An additional survey of random drunken offenders showed that two-thirds had had three or more previous convictions for drunkenness, half had been in prison on that account and probably two-thirds were alcoholics. Three-quarters would have preferred a detoxification centre to a police cell when arrested for drunkenness.

8. It is concluded that it is feasible to manage drunken offenders in a medical and rehabilitative system rather than by the penal system. The effects of adding a detoxification service to a Regional Poisoning Treatment Centre and to a psychiatric hospital led to the conclusion that

the former, in our experience, is not a suitable location, and that staff trained in psychiatric methods are necessary. It is recommended that detoxification centres should be based in hospitals, with a close social work liaison.

It is further concluded that the detoxification and assessment facility was effective for the individuals, though long-term benefit can only be assessed when better rehabilitative facilities are available than was the case in this project. Some implications for the management of future detoxification centres are discussed. A superficial costing exercise indicated that a change from penal to medical management of drunkenness need not be more expensive, and can probably be carried out in Scotland under existing legislation.

FOREWORD

Probably the first person to consider habitual drunkenness as a disease necessitating the attention of doctors was Thomas Trotter in his M.D. Thesis for the University of Edinburgh in 1788: "Ebrietate ejusque Effectibus in Corporis Humanum Complectens".

In an English version of his thesis published in 1804, Trotter wrote: "In medical language I consider drunkenness, strictly speaking, to be a disease; produced by a remote cause, and giving birth to actions and movements in the living body, that disorder the functions of health."

Moreover Trotter recognised psychological components of alcoholism: "It is to be remembered that a bodily infirmity is not the only thing to be corrected. The habit of drunkenness is a disease of the mind. The soul itself has received impressions that are incompatible with its reasoning powers."

Nearly 200 years later I submit this Thesis for the same degree and again suggest that the management of habitual drunkenness should fall within the province of the medical profession.

ACKNOWLEDGMENTS

This thesis is based on the work of a research team consisting of Dr. Cairns Aitken, now occupying the Chair of Rehabilitation Studies at the University of Edinburgh; Dr. Bruce Ritson, Consultant Psychiatrist at the Royal Edinburgh Hospital; Dr. Henry Matthew, lately Consultant Physician in the Royal Infirmary, Edinburgh, and Director of the Regional Poisoning Treatment Centre; Mrs. Ann Griffith, Social Worker; and myself. I am deeply indebted to my colleagues for their invaluable supervision, assistance and encouragement, as well as for their comments and criticisms without which this thesis could not have been prepared. Much of the referral and follow-up of the patients was carried out by Mrs. Griffith who also contributed largely to the section in Chapter 1 on detoxification centres in the USA. The project secretary, Mrs. Margaret McDougall, has at all times been most proficient and efficient, especially in compilation of the data and the typing of this manuscript.

The nursing staff in the wards where the detoxification project was located carried out unenviable tasks with skill and humanity, and to them and the medical staff in the Royal Infirmary, Edinburgh, and the Royal Edinburgh Hospital are due our fullest thanks. In addition, Mrs. Mary Paterson, nursing sister in the Royal Edinburgh Hospital, assisted with compilation of data on morbidity.

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For her forbearance and understanding I thank my wife.

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I declare that this thesis has been composed by myself.

CHAPTER 1

BACKGROUND : THE NATURE AND EXTENT OF THE PROBLEM

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PEOPLE WHO GET DRUNK

Estimates of the number of alcoholics in the United Kingdom vary from about 40,000 (Parr, 1957) to about 350,000 (World Health Organisation, 1951) with intermediate figures of 70,000 (Williams and Glatt, 1966) and 135,000 (Moss and Beresford Davies, 1968). Such figures can only be compared and used with caution as they depend on differing methodology and symptomatology.

Scotland is generally considered to have a higher prevalence than England and Wales (Morrison, 1964; Warder and Ross, 1971), and Whittet (1970) gave a figure of 0.62% for both sexes. The Clayson Committee Report (Scottish Home and Health Department, 1973) reviewed previous research on the prevalence in Scotland and concluded that if habitual excessive drinkers were included in an equal number, then about two percent of the population of Scotland was regularly drinking to excess, giving a total of about 75,000 people.

It is likely that the number of alcoholics is increasing as there have been rises each year of late in various measures relating to alcohol (Zacune and Hensman, 1971; Glatt, 1974). The number of patients admitted to psychiatric hospitals with a diagnosis of alcoholism has

been rising each year, though there are other variables to be considered such as an increased rate of referral by general practitioners, greater acceptance by patients of referral or admission, psychiatrists being more willing to admit the patient and more sensitive diagnostic criteria.

In Scotland there has been an increase of 89% (from 2,610 to 4,926) in the number of admissions to psychiatric hospitals for alcoholism between 1965 and 1973, accounting for 20% of all admissions in 1973 (35% of all male and 8% of all female admissions) (Scottish Council on Alcoholism, 1975). In the Royal Edinburgh Hospital in 1973, 29% of all male admissions and 10% of all female were given a primary or secondary diagnosis of 'alcoholic disorder'. Between the years 1968 and 1974, 20% of all males admitted to the Regional Poisoning Treatment Centre at the Royal Infirmary, Edinburgh, have been considered alcohol addicts or chronic alcoholics, and a further 28% excessive drinkers (Holding et al, 1975).

The Annual Report of the Scottish Council on Alcoholism (1975) states that 70% of over 1,000 male admissions to Glasgow's Western Infirmary with head injury in 1974 were drunk on admission and that head injuries accounted for 26% of all acute surgical admissions to that hospital.

The total consumption of alcoholic beverages and the amount of money spent by the public on them rises each year.

It is generally believed by workers in the field of alcoholism that relatively more women are becoming alcoholics and also more younger people. The number of convictions for drunkenness offences is rising (see below) as are those for under-age drinking and for offences involving drinking and driving.

There are then an increasing body of people drinking alcohol excessively. Besides alcoholics there are those variously described as problem drinkers and regular heavy drinkers. On certain occasions normal social drinkers will also become drunk.

There is no medical or legal definition of drunkenness. The Oxford English Dictionary defines 'drunkenness' as 'the state of being drunk' and 'drunk' as 'overcome by alcoholic liquor'. People may be drunk in licensed premises, motor vehicles, on the street or inside their homes. Probably most of those drunk in public do not come into contact with the police and many of those who do will be 'helped on their way' home. The more frequently an individual drinks to drunkenness, and the less likely he is to have a home of his own, the more probable is it that he will be apprehended for being drunk.

LAWS RELATED TO DRUNKENNESS

a) CONTROLS OVER ALCOHOL

Controls over the misuse of alcohol are social, fiscal and legal. By social controls are meant the disapproval expressed by the community over certain acts, such as exhibition of drunkenness. These attitudes can be reflected in police practice and the sentencing of offenders by magistrates. Fiscal controls involve taxation of alcoholic drinks. Besides laws concerning drinking and driving, licensing of premises to sell alcohol and fixing the age at which it is legal to buy alcohol, the UK has laws making it illegal to be drunk in certain circumstances.

b) HISTORICAL REVIEW

The concept of the condition of alcoholism is relatively recent but alcohol itself has been in existence for a very long time. The chemical is easily produced by the action of naturally occurring yeasts on naturally occurring sugars such as are present in grapes, barley or apples. Wines have been used in religious ceremonies - the Bible refers to 'wine which maketh glad the heart of man' while Pasteur called it 'the most healthful and hygienic of beverages'. But for as long as man has been using alcohol he has also been misusing it. One of the

oldest references (quoted in Roueché, 1960) is that of an Egyptian author some 3,000 years ago: "Take not upon thyself to drink a jug of beer. Thou speakest and an unintelligible utterance issueth from thy mouth. If thou fallest down and thy limbs break there is none to hold out a hand to thee. Thy companions in drink stand up and say 'away with this sot' and thou are like a little child." The Old and New Testaments and ancient writings in Greek, Roman and from other civilisations refer similarly to the evils of drunkenness.

Before the industrial revolution, British society was mainly rural and there were few laws dealing with alcohol and drunkenness, other than the common law offence of being a public nuisance. In 1495 and 1503 magistrates were given some control over ale houses and these were first licensed in 1552. By 1600 there were local bye-laws regulating hours of opening.

Public drunkenness first became an offence in 1606, the punishment being a fine of five shillings or six hours in the stocks. The austerity and discipline of the times of Cromwell gave way to laxity at the time of the Restoration.

Legal controls over the production and selling of alcoholic drinks by licensing was the method used by Parliament in the first half of the 18th century: Hogarth's 'Gin Lane' days (Coffey, 1966). The consumption of gin in

England in the period 1685 to 1750 rose from about 500,000 gallons to over 1,000,000 gallons, most of the consumption being by the poor of London. The effects have been artistically portrayed by William Hogarth in his paintings 'Gin Lane', 'Beer Street' and 'The Rake's Progress'; and prosaically described by Henry Fielding (1751, 1752). Although immigration to London was continuous in this period, the population declined and contemporary writers (Webb and Webb, 1903) ascribed the increased deaths to excessive gin drinking. Inn signs proclaimed 'Drunk for a penny, dead drunk for twopence, straw for nothing' (Smollet, 1848). In some parts of London one house in five was a gin house and it seemed as if the whole population was either engaged in making, selling or consuming gin. There was 'a perfect pandemonium of drunkenness'. Fielding asked, "What must become of an infant who is conceived in gin, with the poisonous distillation of which it is nourished, both in the womb and at the breast." Mothers and 'baby-minders' from the workhouse quietened their children with gin which can only have contributed to a tragic infant mortality rate. In the period 1730 to 1749, 75% of infants died before the age of five years (Coffey, op.cit.).

Parliament was populated by Gentlemen Farmers on whose land grew the corn to supply the distillers with their raw materials. In 1689 Parliament allowed anyone to distil gin on payment of low excise duty and in 1701

allowed anyone to sell spirits. By 1729 gin drinking had become so bad that the excise licence fee was raised to a considerable amount and duty put on each gallon sold. The illegal production of poisonous spirits led to Parliament repealing the act four years later. Again drunkenness increased to such an extent that Walpole in 1736 reimposed the duties at increased amounts. The London gin drinkers rebelled with riots and flagrant disobedience of the law. Matters continued to deteriorate until 1751 when the populace was ready to accept new legislation reinforcing the 1736 act and increasing the penalties for illegal manufacture and sale.

The 1751 Act was more effective and gin drinking decreased. Another factor at the time was the preaching of John Wesley for even though Methodists allowed beer drinking, they insisted on sobriety. The Temperance Movement, which originated from the alcoholic excesses of these times, began by emphasising temperance in its literal sense, i.e. moderation. Beer and wine being 'natural' beverages were allowed, 'man-made' or distilled spirits were prohibited.

Following the alcoholism epidemic, coffee and tea took the place of alcoholic beverages. The upper classes continued to drink, and get drunk, on prodigious amounts of wine and brandy. Many of the prominent politicians, statesmen and peers, including Prime Ministers, were notorious for their drunkenness.

Beer drinking had always been considered one of the virtues of an Englishman (John Bull was always depicted holding a glass of ale) and in 1722 the annual consumption was the equivalent of 36 gallons for every man, woman and child (Mathias, 1959). The ale house was then, as now, the centre of local social activities. After 1751 the amount of beer drunk increased but by 1830 had decreased to half the previously mentioned figure - a per capita consumption of 18 gallons.

In 1787, following a campaign by the anti-slavery social reformer William Wilberforce, a Royal Proclamation was sent to all magistrates as a result of which there was tighter control over public houses; but by 1828 public opinion had again changed with the result that a Parliamentary committee advocated free trade in alcoholic drinks and easier availability. Ale houses flourished and rising to the competition, the old gin houses set out to attract customers again and the national consumption of alcohol again started to rise.

In October 1830, 50 new beer shops opened in Liverpool every day and throughout the country the number grew rapidly (Webb and Webb, 1903). Sidney Smith wrote, "The new Beer Bill has begun its operations. Everybody is drunk. Those who are not singing are sprawling. The sovereign people are in a beastly state."

In the 19th century however the Temperance Movement had been established and following its pressures Parliament set up a Select Committee in 1834 "to enquire into the Extent, Causes and Consequences of the prevailing Vice of Intoxication among the Labouring Classes of the United Kingdom in order to ascertain whether any Legislative Measures can be devised to prevent the further spread of so great a National Evil" (Home Office, 1971). A police magistrate in evidence to the committee stated that as public drunkenness was not an offence, the police would only assist those drunk and incapable. "The police do not interfere with any person who is capable of getting home; and if they give him a little assistance, they do not take him. If he has a friend and is unconnected with the disorder in the street, we do not interfere with him."

A Commissioner of Police said in his evidence to the committee that on the directions of the Secretary of State, the police "took for safety all persons incapable of taking care of themselves; they were confined till morning and then released by the Superintendents when sober . . . . Now every person is carried before a magistrate and dealt with by a magistrate." The result was the person being discharged unless he was guilty of disorderly behaviour. Another police magistrate stated that the number of those drunk and incapable in London in 1833 was 29,880 and of 'drunk and disorderly' 8,560. (There were thus 38,440 for a London population of about 1,500,000, or a rate of six times the present day figures.) It is of interest that the male : female ratio

has changed from about 2 : 1 in 1833 to nearer 20 : 1 nowadays.

The Select Committee advocated much stricter licensing laws but it was not until 1839 and 1869 that legislation was enacted. Demands for control over public drunkenness eventually led to the beginning of modern legislation in 1872.

c) EXISTING LEGISLATION:

In disuse

Though remaining on the Statute Book legislation dealing specifically with habitual drunken offenders from the end of the last century has fallen into disuse.

The Habitual Drunkards Act 1879 provided for the establishment of 'retreats' to which habitual drunkards could be admitted voluntarily for treatment for a maximum of two years unless released earlier on licence. The 'retreat' was licensed by Justices and defined as "A house licensed for the reception, control, care and curative treatment of habitual drunkards." No such houses ever existed.

Compulsory detention was introduced with the Inebriates Act 1898 by which (section 1) "Any habitual drunkard convicted on indictment of an offence punishable by imprisonment, if the offence was committed when the defendant was under the influence of drink; or if

drunkenness was a contributory cause", could be sent to a State or certified Inebriate Reformatory for up to three years. By section 2 of the same Act any person guilty of four drunkenness offences in the course of 12 months could be sent, with his consent, by magistrates to an Inebriate Reformatory ("the Managers of which are willing to receive him") or by a Higher Court without his consent.

The State Reformatories differed from the certified Inebriate Reformatories run by local authorities. Two of the former and 13 of the latter were established but all had closed by 1921. The reasons for the failure seemed to be mainly financial. Legislation enabled rather than compelled the Treasury to contribute funds to local authorities and when central funds were not forthcoming plans for building Reformatories were shelved. In the few places where they were established local magistrates were reluctant to fill the institutions as the costs of these came from the rates.

In use

Modern legislation dealing with drunkenness dates from 1872 when in England the Licensing Act made it illegal to be drunk on a highway or other public place, whether a building or not, or on any licensed premises. The maximum penalty under this section of the Act was fixed at a fine of £5. Such 'simple drunkenness' not involving other unlawful behaviour embraces the offence

known as 'drunk and incapable', the drunken person being incapable of taking care of himself.

The same Act makes illegal other forms of anti-social behaviour in association with public drunkenness and most commonly used is the term 'drunk and disorderly', the maximum fine being £10 or 30 days imprisonment.

Other 'aggravated' offences include being 'drunk and indecent', and the same Act makes an offence being drunk in charge of any carriage, horse, cattle or steam engine or while in possession of any loaded firearms. The Licensing Act of 1964 made it illegal to refuse or fail while drunk to quit licensed premises when asked. The Licensing Act of 1902 made it an offence to be drunk in charge of a child. Besides these, similar offences are to be found in the Town Police Causes Act 1847, the London Hackney Carriages Act 1843, the Merchant Shipping Act 1894 and the Metropolitan Police Act 1839.

In Scotland the corresponding legislation to the English 1872 Act is section 70 of the Licensing (Scotland) Act 1903. Para (1) reads:

> "Every person found in a state of intoxication, and incapable of taking care of himself, and not under the care or protection of some suitable person in any street, thoroughfare or public place, whether a building or not, or any licensed premises, and every person who is drunk while in charge in any street or other place of any carriage, horse, cattle, or steam engine, or when in the possession

of any loaded firearms, shall thereby be guilty of an offence, and may be taken into custody by any constable and detained in any police office or police cell, or other convenient place, and not later than in the course of the first lawful day after he shall have been so taken into custody, shall be brought before a sheriff or any one justice of the peace or magistrate, or if not so taken into custody, may be summoned to appear before a sheriff, justice of the peace, or magistrate, and on being convicted of such an offence shall be liable to a fine not exceeding forty shillings and failing payment imprisonment for a period not exceeding 30 days.

Every person who in any street, thoroughfare or public place, whether a building or not, or on any licensed premises, behaves while drunk in a riotous or disorderly manner, or while drunk uses obscene or indecent language to the annoyance of any person, shall be liable on summary conviction to a fine not exceeding forty shillings, and failing payment to imprisonment for a period not exceeding 30 days, or in the discretion of the court to imprisonment for a period not exceeding 30 days."

It is further stated that 'public place' includes 'any railway station, and any other place to which the public have access, whether on payment or otherwise, and any public conveyance'.

The charge of aggravated drunkenness, e.g. 'drunk and disorderly', is little used in Scotland. Instead those drunks exhibiting anti-social behaviour may be charged with 'breach of the peace'.

Besides these two charges i.e. 'drunk and incapable' and 'breach of the peace' which account for nearly all drunkenness charges in Scotland, there are other Acts and bye-laws which may be used depending on the particular circumstances in which the drunken person is found. For instance the Trespass (Scotland) Act 1865 section 3 may be preferred against a drunk found in a derelict building.

In Edinburgh the local bye-laws and orders were consolidated by the Edinburgh Corporation Order Confirmation Act 1967. The two most common offences with which drunks are charged in this respect are section 483 (1) and (2), the former referring to begging and the latter stating, "A person shall not conduct himself as a vagrant", and continues, "For the purposes of this subsection 'vagrant' means a person having no known fixed place of abode and having no lawful means of obtaining his livelihood". Section 448 is sometimes used and states simply, "A person shall not commit a nuisance in any public place". If the drunk collapses he may be charged under section 464 which makes an offence to "stand, loiter, sit or lie in any public place to the obstruction or annoyance of any person". If he hungrily looks for something to eat in a dustbin he is liable to be charged under section 474, "A person shall not remove or search or disturb or otherwise interfere with the contents of any bin provided for the collection or reception of refuse, food waste, waste paper or litter".

Penalties for all drunkenness offences in England and Wales and in Scotland have been increased by later legislation.

The charge 'drunk and disorderly' can be used in Scotland, but is not often preferred because of the different discretion of the prosecuting authorities. In 1974 only 196 out of 17,752 (about 1%) offences of drunkenness in Scotland were for 'drunk and disorderly', 157 of these being in Dundee and Aberdeen, and none in Edinburgh (Scottish Home and Health Department, 1975). The distribution of charges preferred varies between Scotland and England, and between London and the rest of England (two-thirds of the drunks in London are charged with simple drunkenness, only one-third in the rest of England). Table 1.1 shows the relative distributions (Willcock, 1972):

Table 1.1

RELATIVE DISTRIBUTIONS OF DRUNKENNESS OFFENCES

Charge	Scotland	London	Rest of England & Wales
Simple drunkenness	38.7%	67.0%	35.9%
Drunk and disorderly or breach of peace	37.1%	27.1%	48.4%
Drunkenness + another charge	7.4%	2.0%	12.2%
Another charge only (offender being drunk)	16.8%	3.8%	3.4%

SIZE OF THE PUBLIC DRUNKENNESS PROBLEM

a) HOW MANY OFFENCES?

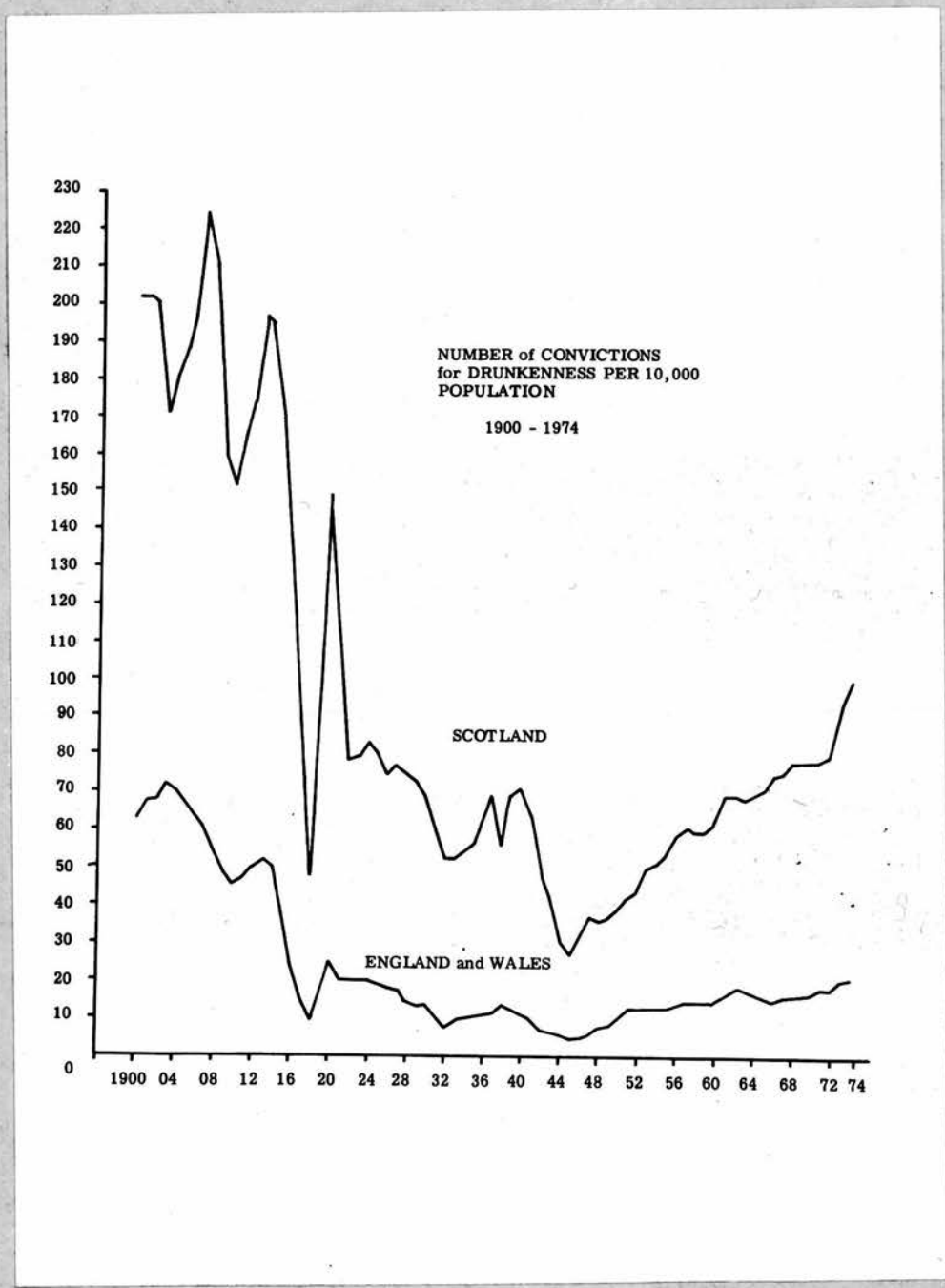
Fig. 1 shows the number of offences per 10,000 of the population in Scotland and in England and Wales this century.

The populations have been derived from the Registrar General's Annual Reports and estimated populations for 1974 from Population Projections (Office of Population Censuses and Surveys, 1974).

The statistics for Drunkenness Offences are taken from the Parliamentary Papers 'Judicial Statistics for England and Wales', 'Statistical Abstract for the United Kingdom', and 'Offences of Drunkenness'.

The Scottish statistics are taken from Parliamentary Papers 'Statistical Abstract for the United Kingdom', 'Judicial Statistics for Scotland', 'Report on the Judicial Statistics for Scotland', and 'Scottish Criminal Statistics'.

Fig. 1


NUMBER of CONVICTIONS
for DRUNKENNESS PER 10,000
POPULATION
1900 - 1974
SCOTLAND
ENGLAND and WALES
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
20
10
0
1900 04 08 12 16 20 24 28 32 36 40 44 48 52 56 60 64 68 72 74

In England and Wales in the period 1961-71, the number of offences of drunkenness each year has been in the region of 74,000-86,000 (about 15 to 18 per 10,000 population). This rose in 1972 to 90,198 (18.40 per 10,000) and in 1974 to 103,203 (20.9 per 10,000). The number of offences has doubled since 1950 and the 1974 figure is the highest since 1915.

The figures for England and Wales are those of findings of guilt for drunkenness offences and include those for a) simple drunkenness, b) drunkenness with aggravations (e.g. drunk and disorderly), and c) cases in which a person was found guilty of drunkenness when being dealt with by the court for some other offence. The figures do not include offences under Road Traffic Acts e.g. drinking and driving offences.

It is not possible to directly compare Scottish with English figures as the former are given in official publications only for 'drunk and incapable'. A formula has therefore been devised to calculate a Scottish equivalent. As the Scottish figures published are those 'proceeded against' rather than the English 'found guilty' some assumptions have to be made to convert the Scottish figures. In the case of drunk and incapable offences, over the 15 years from 1959 to 1973, a mean of 1.36% (range 0.66 to 2.07) of those proceeded against were discharged without trial or were acquitted after trial. In 1973 0.15% of those tried were acquitted and, for

these purposes, it is assumed that 0.15% of those untried and forfeiting bail would be 'not guilty'. Thus a total of 1.36 plus 0.15, rounded up to 2%, should cover all those proceeded against who would be found not guilty. Thus 98% of the published Scottish figure gives the equivalent 'guilty' figure.

For breach of the peace, 6.26% (range 4.94-7.34) were discharged without trial or acquitted. Of those tried 0.01% were acquitted, and the addition of 6.26 plus 0.01 has been rounded up to a 'not guilty' figure of 7%. The Report of the Clayson Committee on Scottish Licensing Laws (Scottish Home and Health Department, 1973) quotes Avison, a criminologist, giving a figure of 'almost half' the persons proceeded against for breach of the peace being intoxicated. The exact figures from Avison's study are not available and for these purposes it has been assumed that the 'almost half' is 45%. (Avison stressed that his results were likely to be underestimates.) If 93% of the breach of the peace offences are guilty then 45% of this figure gives an equivalent number to those who in England might be found guilty of drunk and disorderly behaviour.

From Table 1.1 it will be seen that the added drunk and incapable and breach of the peace figure will only account for 75.8% of all Scottish figures for drunkenness offences, 24.2% being composed of begging, vagrancy, nuisance, etc. It will thus be seen that the previous

figure has to be multiplied by 1.32 to give an equivalent of the total drunkenness offences for Scotland to compare with the English figure.

As Fig. 1 shows, in Scotland too there has been a steady increase in the number of drunkenness offences since the end of the Second World War. The 1972 figure was almost double that of 1950, and the rate of increase has been greater than in England and Wales, with an increase of 25% between 1966 and 1973.

The annual reports of the Edinburgh City Police show that in Edinburgh the number of offenders in the post-war period rose from 1,246 in 1946 to 1,896 in 1954 and remained below 2,600 until 1971. In 1972 the number rose to 3,109; and to 3,811 in 1974 (Edinburgh City Police, 1975), an increase of 50% in four years. The rate in 1974 of 84.7 offences per 10,000 of the population is more than double that of 1954.

Edinburgh's figures are lower than that for all of Scotland owing to Glasgow's greater public drunkenness problem. The Scottish rate however can be seen to be four-and-a-half times that of England and Wales at the present time.

Table 1.2

NUMBER OF CONVICTIONS FOR DRUNKENNESS OFFENCES

per 10,000 population

	Edinburgh	Scotland	England and Wales
1900		202.18	63.34
1910	222.26	150.94	45.10
1920	143.82	148.36	25.52
1930	75.29	68.35	13.40
1940	67.66	71.03	11.23
1950	33.22	39.72	10.84
1960	43.77	61.94	16.17
1970	54.86	78.69	16.82
1971	59.35	77.25	17.77
1972	69.15	79.54	18.40
1973	71.43	93.45	20.19
1974	84.71	99.20	20.93

b) HOW MANY OFFENDERS?

Parr (1962) studied the court records of 935 drunkenness offences in the London area and found 78% of convictions were due to 'once only' offenders, 21% due to habitual offenders. Of the once only offenders, 89% were males; and of the habitual 81% were males. Of all male offenders, 15% were habitual; of all female offenders 26% were habitual. The mean number of offences among the habitual offenders in the previous 12 months was 3.1 (2.8 for males, 4.3 for females). One third of the male and half the female habitual offenders had had ten or more offences in their lifetimes.

This study was carried out in 1957 and it would be interesting to know if the ratios have remained the same for drunken offenders, i.e. habitual : once only remains 4 : 1, and whether the mean of 3 per habitual offender is the same.

Prince (1969) questioned every fourth woman admitted to Holloway Prison in 1967. Of the 637 women 26% appeared to have drinking problems including 12% who had had convictions for drunkenness. She (Prince) also studied the records of the courts supplying Holloway and found that a few elderly women made up for a large number of offences:

Age	Number of offences	Number of women
Under 24	11	11
25-34	30	27
35-44	27	21
45-54	32	25
55 and over	59	12

Eight women in the over 60 age group accounted for nearly a third of all offences for women in that age group in London.

Gath (1969) and his colleagues interviewed 151 men appearing on drunkenness charges in two London courts in 1967-68. In the preceding 12 months, 50% of offenders had had at least one drunkenness arrest. These included 30% who had been arrested three or more times; and this 30% was composed of:

No. of arrests	% of offenders (N = 151)
3-5	10
6-10	10
10-25	6
Over 25	4

The researchers also found that 24% had been arrested within the last month.

The Working Party on Habitual Drunken Offenders (Home Office, 1971) restudied Gath's material and estimated that three-quarters of all men convicted in a year were convicted once only:

No. of convictions	% of offenders (N = 151)
1	76
2,3	16
4-11	7
Over 11	1

The Working Party defined 'habitual' as three offences in the course of a year and reckoned that out of the 71,167 convictions for drunkenness in 1967, some 5,000 were 'habituals'. Prison authorities put the number at 2,000 based on the number and frequency of receptions into their prisons. The Working Party asked Chief Constables in 15 large cities in England and Wales to tell them how many habitual offenders they had passing through their courts. Manchester said 66 men, Liverpool 54 and Birmingham 52 men. The total number in eight cities including Leeds,

Newcastle-on-Tyne, Nottingham and Cardiff came to less than 100 men, a figure which strikes the writer as astonishingly low considering the ease with which he found 100 in Edinburgh in the course of a year. This can mean either Edinburgh has a relatively higher number of such men or the Chief Constables have underestimated their numbers.

As the number of offences per annum in England and Wales has increased by nearly 50% since 1967, it would seem wise to regard the figure of 5,000 habitual drunken offenders as a conservative estimate. It is difficult to make a Scottish estimate from these statistics but Chapter 10 shows that 42% (twice as many as in Parr's study) of random offenders were 'habitual' (3 or more offences in 12 months). There are probably between 2,000 and 3,000 habitual drunken offenders in Scotland.

c) EFFECT ON PRISONS

A certain number of drunken offenders will be disposed of by the court by being sent to prison. Lord Stoneham told the International Symposium on the Drunkenness Offence (Cook et al, 1969) that the prison department of the Home Office had put the number of habitual drunken offenders who were in prison at any one time at about 1,000 out of a total prison population of 32,000. Of these 1,000 perhaps 200 were serving sentences for drunkenness only, the rest for another offence with or without a concurrent drunkenness charge.

Parr's (1962) study of 935 convictions for drunkenness in London courts showed only 10 individuals were sentenced to prison directly, for a period of one to 28 days. The records of the habitual offenders showed the ratio of offences to imprisonment was 30 : 1. In only two of the 935 cases was probation used.

In Gath's (1969) study of 151 offenders, 89% were fined, 5% given a discharge, and 6% sent to prison or remanded for reports.

In the study of London's Skid Row (1966) Edwards and his colleagues found that 40 of the 51 men studied had been in prison, 19 of them more than 10 times. Thirteen of the men said they had in the past attempted to be arrested hoping for a week or two's shelter in prison.

Hensman (1969) studied a group of 180 short-term (three months or less imprisonment) recidivists in a London prison. Thirty-four percent had been in prison for drunkenness and a further 9% for 'petty' offences including begging, using obscene language and being an incorrigible rogue. Half the men had in the past been in prison more than five times, and 63% had been convicted for a drunkenness offence at least once. Forty percent had been convicted for six or more drunkenness offences.

Edwards et al (1971) compared the same 180 short-term with 312 long-term prisoners and concluded: "Among long-term recidivist prisoners, those with severe drinking

problems constitute a not inconsiderable minority. Among short-term prisoners who are not on a drunkenness charge the figures are higher while among those who are in prison on a drunkenness charge pathological drinking of severe degree is more usually present than absent." In the same paper Edwards and his colleagues reviewed the general relationship between alcohol and crime, pointing out that the prevalence rate of alcoholism among prisoners (ranging from 10% in Norris's (1941) study to 56% in the (1965) study by Robinson et al) is highly dependent on the particular definition of alcoholism.

The Report on the work of the Prison Department (Home Office, 1969) showed that in 1968 there were nearly 3,000 receptions (2,719 men and 206 women) into prison for offences of drunkenness. Most of the offenders involved were there on account of fine default and many would pay in whole or in part within a few days of reception. There is thus a comparatively small number of habitual drunken offenders in the prison population at any one time, perhaps between 120 and 220 (Home Office, 1971). The Prison Department told the Habitual Drunken Offender Working Party that 5,000 (one in seven) of the prison population (in 1967) had 'serious drinking problems' of whom rather more than 1,000 were 'habitual drunken offenders' (neither term being defined).

From the number of those frequently out and in prison, the Prison Department estimated that about 2,000 was the

number of habitual drunken offenders in England and Wales, fewer than 100 of whom were females. The Department estimated that 40% of these habitual drunken offenders came from London, the same percentage as the proportion of drunkenness offences convictions for London compared with the total for England and Wales. The Working Party accepted the figure of 2,000 as the best estimate of the number of habitual drunken offenders in England and Wales but cautioned that as many as 5,000 might come to notice over the course of a year.

Only 27 of 1,371 (2%) imprisonments for drunkenness in Scotland in 1973 were without the option of a fine (Scottish Home and Health Department, 1974), though 31% of the 254 imprisonments for vagrancy and trespass were without the option. Forty-three percent of the 5,252 imprisonments for breach of the peace were without the option but it is not known how many of these were drunk on arrest, and there is no evidence to show whether the proportion of those who are imprisoned after conviction for breach of the peace who were drunk on arrest is the same as the proportion of those appearing in court who were drunk on arrest.

However assuming that there is no difference in these proportions, 45% of the total breach of the peace imprisonments could be considered as 'drunk and disorderly' (see page 19). Receptions into prison can be for 'crimes' and for 'offences'. The figures show that in 1973 in

Scotland 41% of receptions for all offences were for drunkenness offences, and these accounted for 23% of all receptions after conviction for all offences and crimes.

CURRENT MANAGEMENT OF THE PUBLIC DRUNK

a) UNITED KINGDOM

Medical

Edwards et al (1973) in a study of the prevalence of alcoholism in Camberwell, London, an area in which there is a large psychiatric teaching hospital as well as the DHSS reception centre for homeless men, reported that 37% of vagrant alcoholics were known to medical sources and less than one-third were in contact with psychiatric hospitals. Not all habitual drunken offenders are vagrants but the figures for resident male alcoholics were similar to the vagrant group with less than half known to a medical source and again only 30% known to psychiatric hospitals (including alcoholism treatment units). Even if a habitual drunken offender who is an alcoholic is known to medical agencies he may not be receiving treatment. Such individuals are often considered to have a poor prognosis and are often excluded from studies of psychiatric treatment of alcoholism.

A review of major research on the treatment of alcoholism in the United Kingdom in the last two decades

shows that in many cases individuals with the usual characteristics of habitual drunken offenders are not included in the cohorts studied. In the studies by Glatt (1961), Walton et al (1966) and Pemberton (1967) there was an excess of those in higher social classes. Morrison (1964) reviewed hospital admissions for alcoholism in Scotland in 1961 and found that those in social classes I and II were greatly over-represented. McCance and McCance (1969) reported that their group matched the general population in social class and they did not exclude 'down-and-outs', but in the study by Rathod et al (1966) such patients were excluded as being 'unsuitable for group therapy' and Edwards and Guthrie (1967) specifically excluded 'vagrant alcoholics of the Skid Row type'.

Those with dementia, schizophrenia or other psychoses are excluded in the last two mentioned studies, and by Davies et al (1956) who also excluded those "whose alcohol addiction was not their central problem (as for example in some psychopaths who were also perverts, drug addicts, pathological liars and swindlers)".

Freeman and Hopwood (1968) commenting on the selectivity of patients by other authors, suggested a misleading impression might be portrayed by them on the problem of alcoholism and how it should be tackled. They excluded only three individuals (one with a record of serious crime, two with dementia) and the majority of 100

individuals in their cohort were in social classes IV and V, unemployed, wine drinkers with police records. Only 36 remained abstinent throughout their hospital stay and 60 did not attend the out-patient clinic for follow-up even once. Twelve attended the out-patient clinic for more than three months, half remaining abstinent, the other six having lapses. These successes had sought admission themselves, had the shortest history, were co-operative and remained abstinent in hospital. They were usually employed, had few physical complications, were married and living with their spouses, and of higher social class.

These are the general characteristics of patients with a good prognosis. Those of lower social class were found to do least well in the studies by Glatt, McCance and McCance (op.cit.), Ritson (1968) and Willems et al (1973). Those who lived alone, were single or had an unstable marriage are mentioned as having a poor prognosis by Glatt, Rathod et al and McCance and McCance (op.cit.) and Vallance (1965). Those drinking fortified wine are mentioned by McCance and McCance (op.cit.) who also stated that a history of delirium tremens was associated with a poor outcome, as did Willems (op.cit.). 'Psychopaths' did badly in the studies by Glatt, Vallance, Rathod et al and Willems et al (op.cit.). Those of low intellect or of intellectual impairment had a poor prognosis according to Glatt and Pemberton (op.cit.). McCance and McCance (op.cit.) specifically mentioned a record of 'police convictions' as one of the characteristics of the 'bad outcome' group.

Besides introducing bias by excluding patients with a poor prognosis many studies do not give figures for others excluded from follow-up data who may have dropped out during treatment, died, moved, refused follow-up interview or in some other way dropped out of the original cohort admitted to the study. Miller et al (1970) found that they could only successfully follow-up 26% of 343 originally referred for admission to an alcohol treatment programme. When they studied those who dropped out at each stage they found that in nearly every case there were statistically significant differences in the expected directions in aspects of marital status, work history, trouble with the law, etc. Again these are the characteristics one would tend to find in the habitual drunken offender type of alcoholic.

Of the many studies on the effectiveness of disulfiram one especially worthy of note (Bourne et al, 1966) discussed the success of the drug when taken voluntarily, and when taken in a 'semi-compulsory situation', by public drunken offenders in Atlanta, Georgia, USA, in 1962-63. A group of 64 'volunteer' patients who had been cleared by the court was compared with a group of 132 who were given suspended sentences and disulfiram treatment in lieu of serving a jail term. Screening for contra-indications to the drug were not intensive (only those with a history of myocardial infarction or the overtly psychotic were excluded) and the physical health of the subjects was poor, but there was not one serious adverse effect to the drug.

Fifty percent of the volunteer group and 46% of the 'semi-compulsory' group were abstinent on follow-up, though the duration of treatment is not given for all patients. The authors concluded that disulfiram can help break the court 'revolving door' pattern of their lives.

If the stated contra-indications to administering disulfiram are followed - in patients with liver disease, respiratory disease including tuberculosis, epilepsy, psychoses (Wilson, 1975) - many 'Skid Row' alcoholics will be excluded. Most do not live with a 'responsible relative or friend' who it is recommended (Malcolm and Madden, 1973) should manage the administration of the tablets. It has also been shown that disulfiram implantation, whilst effective in some trials (Malcolm and Madden, op.cit.; Whyte and O'Brien, 1974) does not give 'therapeutic' blood levels and 'the deterrent effect is purely psychological' (Malcolm et al, 1974).

In a study to evaluate the effectiveness of hypnosis as an adjunct to conventional treatment of alcoholism (Edwards, 1966) two groups each of 20 patients admitted to the Maudsley Hospital, London, were randomly allocated to (1) psychiatric ward treatment, individual psychotherapy, disulfiram, attendance at Alcoholics Anonymous and social rehabilitation and (2) the same plus hypnosis. The hypnosis group did not do any better. There was a correlation in each group between outcome and previous social stability and Edwards commented "bad results with

socially unstable patients are so predictable that it may even be wondered whether it is worth-while taking such patients into hospital. Repeatedly the experience with these men is that they stay sober while in hospital and can even go out to work from the shelter of the ward, but that they are incapable of remaining sober when they go out to live alone in lodgings, and even a hostel is often no substitute for the warmly supportive atmosphere of the ward."

Edwards' comments are supported by the study of Bewley (1969) which is of interest as a treatment programme catering especially for alcoholics with a poor prognosis.

In 1964-66 between 254 and 307 patients were admitted to Tooting Bec Hospital, London, with a diagnosis of alcoholism. Comparison of the characteristics of these patients with those in a special unit for the treatment of alcoholism showed the Tooting Bec patients to be over-represented in social class V, have no family ties and longer criminal records. The men were in poor physical health and management included replacement of dentures, spectacles and minor surgical procedure. The men were prescribed disulfiram, introduced to Alcoholics Anonymous and encouraged to look for work from hospital, which was then used as a night hospital or hostel. Minimal treatment was otherwise given but included support and advice from the nursing staff. When patients became drunk they were moved to a closed ward, their parole stopped, and when sober were restarted on disulfiram and could return to work.

The incidence of episodes of drunkenness amounted to about 1.2 occurrences of drunkenness per day, and the author states that as the number of alcoholics in the hospital varied between 60 and 80 and these were alcoholics who would be generally considered to have a poor prognosis, this incidence seems acceptably low. Bewley concludes that it is possible to treat supportively a large number of poor prognosis alcoholics with minimal treatment and hostel-like supervision. Having a closed ward for those who are started on a drinking bout is useful but the biggest problem is that many such patients do well in hospital but relapse on discharge, and a certain number probably need lifelong hostel supervision.

Edwards et al (1974) showed that the social class of alcoholics was related to the type of hospital, the source of referral, whether they were compulsory or voluntary patients and the type and number of ancillary diagnoses. The study, in 1953-57 compared patients in a large psychiatric teaching hospital, an alcoholism treatment unit, a large general mental hospital and in a psychiatric assessment ward which only accepted compulsory patients.

Those in the lower social classes were most likely to be hospitalised compulsorily, to be referred by the court and to be labelled a 'psychopath'.

The authors hypothesise that there may be two different streams of alcoholism treatment services. The first stream consists of the relatively well staffed

specialised units whose policy resists admission of lower class patients possibly based on the belief that such patients will, because of lack of verbal fluency, fail to benefit from group psychotherapy. Other covert processes are perhaps at work, possibly as a result of the professional class psychiatrist's difficulty in empathising with a working class patient.

The second stream consists of general psychiatric wards of large mental hospitals, reception centres, courts and prisons and the non-statutory organisations. They operate under the handicap of very low staff/patient ratios and deal with the overlapping groups of working class men and down-and-outs.

It seems clear that those with the characteristics of the alcoholic drunken offender - low social class, severe alcohol addiction, personality disorder, a history of failure at interpersonal relationships and poor intellectual ability - are either not treated by psychiatrists or alcoholism treatment units, or when they are, usually do badly. Such individuals have special needs requiring alternative methods of management.

Penal

The drunkard on the street is picked up by the police for his own good. The police are aware of the many dangers to such a drunk - he might be robbed or assaulted, he may become ill or die due to the consequences of his drunken

state and exposure to the elements and to traffic. The attitude of the public in different areas may vary between apathy, sympathy or disgust towards the drunk, but prosecutions do not as a rule take place because the public wish to punish the man, though this is usually the result. Police practice in local courts varies throughout Britain but in general the sequence of events is as follows:

On being found in the street the man is taken by police van to the local police office where he is charged with the offence. He may request and be granted bail and ordered to appear in court the following morning. More usually he will be unable to ask for bail or have any money of his own, or have anyone to put up the bail for him. He will be searched and have his personal possessions documented. He will then spend the night in the police cell, perhaps with several others. Many of the cells, certainly in Edinburgh, are utterly primitive, consisting of a dark room with stone walls, a urinal and perhaps a wooden bench to sleep on. There is a belief among some police officers that such conditions act as a deterrent, but proof is lacking and would only be provided if a study was done on the further offences committed by matched groups randomly spending their first night in pleasant or primitive cells. In my experience the drunk has other influences on his drinking behaviour that affect him more than contemplating that part of the consequences.

The following morning the man is taken to the District Court to appear in front of the magistrate. The kind of people these are again vary in different areas. In Edinburgh the Burgh (or Police) Court changed in 1975 to a District Court but the magistrates continued to be town councillors, known as baillies, with no formal legal, medical or social work training. Among the other accused in the same court will be those charged with rowdiness, assault and shoplifting. The drunken offenders will comprise about half of the cases. The time taken to process and 'D and I' is very short, perhaps a couple of minutes. The man answers to his name and is told that he is charged that (for example) "at 11 p.m. on Monday, 10th June, in the Cowgate he was found drunk and incapable". Asked how he pleads he inevitably answers "guilty". The clerk asks if he admits to his previous convictions, the accused replies "yes". The prosecutor tells the magistrate "unemployed, no fixed abode, 28p on him when arrested". The magistrate asks the man if he has anything to say for himself, the man says "no". The magistrate then admonishes him or fines him £2 or £5. If the man has the money he pays the fine there and then. If not, he may ask for time to pay and be ordered to pay within two weeks.

However, if the man is of no fixed abode, he is considered a 'bad risk' for paying and is given 'no time to pay'. There is some variability as to what is considered by the court a 'fixed abode', the definition being subjective to some degree. Thus in some places a night

shelter might not be considered such and many homeless men end up in prison on this account.[1]

The magistrate may impose a fine bearing some relation to the amount of money in a man's possession: if he has £2 and the magistrate thinks prison might 'do him good' he may fine him £5: or alternatively he may be 'lenient' and fine him £1. By 'do him good' it is not suggested that the magistrate always wishes to punish the man - it is obvious that in many cases the magistrate thinks the only way out of the situation the offender is in is for him to go to prison to be cleaned up, fed and dried out for the sake of his health. Certainly in some cases it is not in the offender's best interests for him to be repeatedly admonished when he is receiving no help of any kind.

My impression after attending the Edinburgh Burgh Court for more than a year is that females tend to be dealt with more leniently than male offenders with the result they can reach a considerably deteriorated state. One female offender in Edinburgh is repeatedly reported in the local press as having a 'record' number of convictions - she has been referred to by the local MP in Parliament (Hansard, 1975). The Member of Parliament was speaking on the role of detoxification centres in a debate 'alternatives to prison'.

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[1] 72% of short-term alcoholic prisoners were of no fixed abode in an investigation of 50 men in Springhill open prison in 1965-66. (Home Office, 1971)

Nearly all drunken offenders plead guilty to whatever the charge though I remember one man indignantly pleading not guilty to a charge of begging, although he was a regular 'D & I'. To plead not guilty if no fixed abode might mean longer in detention awaiting trial than the maximum sentence the court can impose - the men know this as well as the clerk of the court and sometimes there is a little scenario where the man pleads not guilty, is told by the clerk of the court that he will be tried in two months time, the man says he has changed his mind and wants to plead guilty and is then dealt with.

In some cases the offender does seem to want to go to prison and to a few this is their 'home'; they will say it is the only place where they feel secure. These prison 'regulars' can be popular figures among the prison officers and have certain minor 'privileges' (like making tea for the officers). Most alcoholic offenders will probably receive some offer of help in the prison, but with repeated imprisonments the welfare officers will, like everyone else, begin to despair as they find their efforts fruitless and ineffective. Sometimes the offender may find some help from Alcoholics Anonymous groups when in prison.

If the man has some money in his possession when imprisoned he may use it to pay part of his fine and so not need to serve the whole sentence. One amusing phenomenon is the system set up by a gang of offenders to release each other. When one is released he obtains enough money from

social security or elsewhere to pay the fine of another who then releases a third and so on until the gang are all freed. They then pool the remaining money to buy alcohol. Often a man released from prison starts drinking again immediately he leaves the prison gate, being perhaps met by one of his cronies. Inevitably many are back in court the following morning.

One patient in the present study (a control) had 33 convictions for drunkenness offences in 1974, spending a total of 330 days in prison that year. In his lifetime (he is aged 53) he has had over 130 convictions for drunkenness offences and I have estimated that he has spent an accumulated total of over 10 years in prison on account of his alcoholism. (In perspective it may be noted that murderers can be released after a lesser number of years.) The longest time this individual had out of prison in 1974 was 10 days. In one period of 138 days there was only one day when he was not in prison.

Though they are usually not difficult prisoners, the prison officers do not welcome drunken offenders realising there is little they can do to help them in the long run. Prison is not the best place to dry out a drunk. In Scotland there is no formal prison medical service and offenders will talk of the lack of full treatment of their alcohol withdrawal symptoms. Prison does not help their already low self esteem and morale and it is not surprising that their resentment leads them to resume drinking immediately on discharge.

An alcoholic (McCulloch, 1975) writes that imprisonment sometimes comes as a relief. The chance to get washed, shaved, fed and supplied with tobacco is often genuinely appreciated. McCulloch writes "But of course the aspect of prison life most appreciated is the opportunity to get 'dryed out' and get fit enough to enjoy a good bevvy on release. And this is inevitable; for, as your time for release approaches, the tension mounts ('gate fever') to a level where it can only be relieved in an explosive and climacteric manner."

Ross (1971) compared 40 alcoholics in the Alcoholism Treatment Unit of the Royal Edinburgh Hospital with a small group of 18 prisoners, not all imprisoned for drunkenness offences and selected by a prison nursing officer who "knew the man to be an alcoholic". Despite these and other criticisms of Ross's methodology the study did find that the prison alcoholics differed from the hospital alcoholics by being of lower social class, older, drank more alcohol, spent more time drinking and more time drinking alone, had more "loss of control" features. The prisoners tended to drink cheap wine while the hospital patients drank beer and spirits. There were no differences between the two groups in the degree of psychological disturbance as identified by psychological tests (Cattell's 16 Personality Factor questionnaire, Fould s' Symptom-Sign Inventory and the Hostility and Direction of Hostility Scale). Ross concluded that alcoholics in prison were in as great need of treatment as hospital alcoholics, that the present

procedure for dealing with alcoholics was costly and ineffective, and that current hospital treatments for alcoholics showing the same features as prison alcoholics was ineffective.

Ratcliff (1966) commented on the 1,180 imprisonments of men in Scotland in 1965 for drunkenness offences. All but 80 were in default of payment of a fine and on 30 occasions the jail sentence was more than 30 days. In 16% of the admissions there was no previous imprisonment, in 27% there had been 1-5, in 25% 6-10 and in 31% over 10 previous imprisonments. The author wrote of imprisonments rather than individuals imprisoned, thus these figures will include individuals counted more than once during the year. Ratcliff 's 'profile' was of a Scotsman aged between 30 and 60, unskilled but literate who had elected (sic) to return to prison as likely as not for at least the seventh time, for a term extremely unlikely to exceed a month, rather than exercising the option of paying a fine. He concludes that compulsory detention of an alcoholic in prison is largely ineffective as a treatment measure.

b) <u>EASTERN EUROPE AND SCANDINAVIA</u>

The management of the public drunk varies in each European country but in Eastern Europe and Scandinavia the approach is through detoxification centres.

In Poland and Czechoslovakia the problem is primarily one of sporadic acute drunkenness from 'celebratory' spirit drinking by what are otherwise healthy and relatively socially stable men, as compared with the UK and USA habitual drunkenness in homeless men.

In Poland since 1956 sobering up stations have been established in all cities and towns, with bed numbers ranging from 15 to 150 (Tongue, 1969). Drunkards are usually brought there by the police, or more infrequently by a friend or relative. The man is then transferred to medical personnel, physically examined, bathed and put to bed. He must stay for a minimum of eight hours and a maximum of 24 hours. The following morning he leaves, having paid for his 'bed and breakfast' and if he is not readmitted within two months no further action is taken. If he does, he is referred to a 'commission' who investigate the situation to decide whether the patient needs in-patient or out-patient treatment. Any decision on compulsory detention has to be taken by a court of law.

In Czechoslovakia the first sobering-up station was opened in Prague in 1956, the objective being to provide emergency medical care for the acutely intoxicated. The Prague unit is staffed by doctors, nurses and social workers together with alcoholic patients ready for discharge from nearby in-patient psychiatric units. Referrals can be accepted from anyone. The drunk can be detained for a maximum of 12 hours.

Patients seen in acute states of intoxication that endanger either their health or their surroundings, or the public, are taken by police in an ambulance to the station, put to bed and given any necessary treatment (Chafetz, 1961). When they become sober they are released and charged for the 'drying out' service and transport. On discharge from the station the patient's name is placed on the district list of the alcoholic centre and he must thereafter report for a lecture on alcoholism and its consequences, usually held on Sundays. The district doctor will also call on him to evaluate whether or not he is an alcoholic. When a social problem is apparent, a social worker is called in to gather more information. When the district doctor makes a diagnosis of alcoholism, or if the patient shows up at an anti-alcoholic station a second time, the psychiatrist is called in, and long-term therapy is begun. Most stations are open at night and in large industrial towns are open continuously. They are staffed principally by male nurses, and psychiatrists who specialise in the problems of alcoholism are on duty. All stations are set up as annexes of medical facilities, so that the whole treatment programme may be integrated. The anti-alcoholic station therefore functions primarily for early detection of alcohol problems and provides medical treatment for acute alcoholic states.

USSR

The Russian authorities do not nowadays deny that there is a large problem of alcoholism in the Soviet Union, and that there is considerable public drunkenness. In general the Soviet attitude towards the alcoholic patient tends to be moralistic and punitive (Chafetz, 1961) and in an article entitled "The Soviet people think that the state should be more stringent about drunkenness" (Novosti News Agency, 1970) the USSR Deputy Minister of Internal Affairs described work therapy centres which handle, according to the rulings of courts of law, "the most inveterate drunkards who refuse to have voluntary treatment and systematically violate law and order. A strict isolation of alcoholics, compulsory treatment and, the main thing, correctional instruction through work therapy, provide positive conditions for bringing them back to a normal way of life."

The editor of the Journal of Studies on Alcohol visited the Soviet Union in 1973 (Keller and Efron, 1974). There were 29 municipal sobering up stations (vytrezvittli) in Moscow, 28 for men and one for women. The system operates by the use of small radio-equipped autobuses which cruise about the city. If a drunken person on the street is reported, one of these cars is despatched to pick him up. First offenders are released in the morning; they must pay for the transport and services. Second offenders are charged more; the amount being determined

administratively by a police officer according to a schedule which seemed to have a considerable margin of discretion and takes into account the severity of the offence and ability to pay. Repeaters are invited to attend group therapy meetings with their families, and may be reported to their local out-patient clinic which invites them to seek treatment. The administrators of the stations consider that between 3 and 5% of the men brought in are alcohol addicts, the rest being casual drunks. Before the patients are released in the morning they are given a little talk on the 'evils of alcohol'. The report on the visit concluded with the impression that "the police were performing an efficient service in coping, relatively unobtrusively, with the problem of complaint-evoking drunkenness in the streets".

Sweden

In Sweden the Government has accepted that penal measures against drunken offenders are ineffective, and a Government Commission has responsibility for the establishment of medical detoxification facilities where public drunks can be detained for up to 24 hours (Home Office, 1971; Wiklund, 1969; Bremberg, 1967).

The control of alcohol in the community is invested by law in elected local temperance committees who deal with all matters concerning alcohol and its abuse including licensing of premises and issuing of driving licences.

Most referrals of individuals to the committees come through the police, usually after an individual is arrested for drunkenness, though referrals do come from individuals themselves or from their spouses or relatives. Doctors must report cases of alcoholism not already under treatment. After referral the committee will then 'investigate' the individual's case including interviews with relatives, neighbours and employers, and offer help through social work, medical care, etc. The individuals can be put on compulsory 'probation' and ordered to have his activities surveyed by a helper, either one of the temperance committee personnel or a layman. If this fails, the individual can be detained for treatment for a year and recidivists for four years, though in practice the maximum time in an institution is six months.

There are 2,000 beds in Sweden in such 'nursing homes' and a third of admissions are voluntary. During the patient's stay, discussion will take place on treatment and aftercare involving social workers, psychiatrists, psychologists, occupational therapists, employment advisers, representatives of the temperance board, and the patient himself. These institutions provide a humane type of detention: the homes are comfortable with single rooms, good food, sport and leisure activities and job training. They have no walls and no guards and the few that escape are sent back. Those unable to be successfully rehabilitated may pass to one of the many labour camps present throughout Sweden. These are run by the department

of employment, and habitual offenders can live and work there on a voluntary basis and leave when they wish. They are paid reasonably well for their work in lumbering or road making and are allowed to drink at the week-ends. These camps offer a reasonable way of life for men who are unable to adjust to everyday society but can function reasonably well on their own.

Finland

I visited Helsinki in June 1975 and found that public drunks were to be found everywhere in the city; when they became anti-social they were good-humouredly 'moved on' by the police, or taken to a shelter managed by the city corporation and having the most rudimentary of facilities. The proliferation of public drunkenness is the result of decriminalising the law against public drunkenness in 1969 while not providing any detoxification facilities.

Finland, like the USA, had total prohibition in the 1920's and those found intoxicated were fined or imprisoned. The prohibition law was repealed in 1932 and further liberalisation of the law led to an Alcohol Act in 1969 which removed drunkenness from criminal status. The punishment for public drunkenness was no longer considered relevant because undergoing the generally practised punishment of substituting prison for fines did not serve the original purpose of the fine levies. Drunkenness remained an arrestable offence. The number of men arrested for

drunkenness has decreased (from 168 per 1,000 men in 1923 to 136 arrests per 1,000 men in 1970) but the average number of arrests per arrested man has increased in that period from 1.6 to 2.5 and the share of men arrested once from all those arrested has fallen from 74% to 61% (Säilä, 1975).

c) USA AND CANADA

Pittman and Gordon (1958) studied the records of 1,357 men sentenced to prison in an American county on charges of public drunkenness. Only five of these men were in prison for the first time. About one third of the men were in for the second to tenth time. Nearly 60% had been in prison 10-25 times before and 96 men (7%) had had 25 or more previous times in prison. It was clear the author said that "jailing has not deterred them from further public drunkenness". The authors continue, "These men are not rehabilitated in the penal institutions. Any belief that punishing them by a jail term in the county penitentiary will solve their problem is an illusion. It must be recognised that repeated jailing, as a socially and legally accepted philosophy in the community for reforming the chronic inebriate, has been and will continue to be a failure - aptly termed the revolving door policy - unless radical changes are instituted by the society."

Pittman and Gordon's book "The Revolving Door" joined the works of Straus (1946), Rooney (1961), Jackson and

Connor (1953) and Rubington (1958) as the forerunners in stimulating new ideas about the management of habitual drunken offenders in the USA. In the last 10 years there have been major changes involving transfer of management of public drunks from the penal to medical and rehabilitative sources. Among the important stimuli to change was the decision by the American Medical Association (1956) to formally recognise alcoholism as a disease.

In 1966, the Federal Bureau of Investigation reported 1,485,562 arrests for public drunkenness, which amounted to 40-50% of the total arrests for all offences. The cost of handling and maintaining the drunkenness offenders in county or city jails was $100 million annually (Gammage et al, 1972).

In the same year two court cases precipitated considerable legislature to help the chronic alcoholic (Goff, 1969). 'Driver v. Hinnant' resulted in a Court of Appeals, affecting five States, stating that alcoholism is an illness and any criminal conviction for the disease must be interpreted as 'cruel and unusual punishment'. In 'Easter v. District of Columbia' a Court of Appeals found 'no criminal intent' when a confirmed alcoholic became intoxicated in a public place. This ruling applied only to the District of Columbia but as a result, there were then six areas which were prevented from criminally prosecuting or jailing chronic alcoholics for public drunkenness.

It remained for the Supreme Court to make a definitive ruling along these lines for the whole country to be required to abandon criminal prosecution of drunkenness offenders, and to reconsider the sentences for all alcoholics involved in criminal offences. The 1968 case of 'Powell v. Texas' was expected to be such a case (Driver, 1969), but the Supreme Court declined to issue a federal constitutional mandate for defence through the Eighth Amendment (prohibition against 'cruel and unusual punishment'). This does not, however, prevent the individual states from creating a defence of alcoholism to the charge of public intoxication (Hollister, 1970). There has not yet been a Supreme Court ruling, but there has been a considerable amount of legislation both federal and state to establish treatment facilities for alcoholics and in some states to abolish imprisonment for drunkenness offenders.

A "Task Force on Drunkenness" report by the President's Commission on Law Enforcement and Administration of Justice in 1967 recommended that:

1. "Drunkenness should not in itself be a criminal offence. Disorderly and other criminal conduct accompanied by drunkenness should remain punishable as separate crimes. The recommendation requires the development of adequate civil detoxification procedures."

2. "Communities should establish detoxification units as part of comprehensive treatment programmes."

3. "Communities should co-ordinate and extend after-care resources, including supportive residential housing."

4. "Research by private and governmental agencies into alcoholism, the problems of alcoholics, and methods of treatment should be expanded. Consideration should be given to providing further legislation on the Federal level for the provision of the necessary co-ordinated treatment programmes."

Federal funds for acceptable state programmes for the provision of alcoholism treatment facilities were made available by the 'Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act' of 1970. The next year the 'Uniform Alcoholism and Intoxication Treatment Act' was drafted by the National Conference of Commissioners in Uniform State Laws. This act was intended to be adopted by each state.

The legal difficulties centred on determining criminal responsibility for alcoholics; the question of whether or not the accused had free choice in taking the drinks that led to his public drunkenness or his drunken driving or the crime that he committed while under the influence of alcohol. If the charge of 'public drunkenness' should be abandoned altogether because it is 'cruel and unusual' to punish a man for manifesting symptoms of an illness, could not the same defence be made against punishment for serious crimes committed when drunk? These problems remain to be clarified and it will take some time before all the legal complications are worked out. The federal government

seems to be holding back on eliminating the possiblity of sending men to jail for drunkenness until there is adequate provision for treatment as an alternative. The question of whether treatment is more effective if it is voluntary or mandatory also is important.

The District of Columbia was forced by the 'Easter' decision to provide detoxification facilities immediately as an alternative to jail with the result that these facilities are not adequate to cope with the problem. Other areas have been able to plan their facilities more carefully and have had more successful results. Many places are still arresting men for drunkenness although they have detoxification and other treatment facilities which are being used on other occasions by the same men.

The 28-bed St. Louis Detoxification and Diagnostic Evaluation Centre opened in 1966, one of the earlier detoxification centres in North America and the first to be sponsored by a metropolitan police department. It was the outcome of a programme begun in the late 1950's by David Pittman to train the St. Louis police to recognise and to understand the problems of alcoholism. Several organisations and individuals became interested in the Skid Row alcoholic and established a 'sobering-up station'. The police took those drunk in public to the centre rather than arresting them. After the police left them, their stay was voluntary. The seven-day detoxification programme

consisted of the individual passing from the intensive care unit (where he received medication to help withdrawal symptoms) to the ambulatory care section where treatment involved counselling, evaluation, group meetings, educational lectures and films and Alcoholics Anonymous meetings.

A small scale evaluation (Root, 1970) on 160 patients four months after discharge measured drinking, employment, income, health and housing. One half showed significant overall improvement, 47% showed improvement in drinking pattern, 49% had improved in health, 18% in employment, 16% in income, 15% in housing. In the three months prior to first admission 46% had been arrested. In the three months after discharge 13% were arrested.

Also in St. Louis, Pittman and Tate (1969) compared two programmes for alcoholics in treatment from 1962 to 1964. They studied a sample group of 177 patients who were initially detoxified, then given extensive diversified in-patient treatment for from three to six weeks. They had medical, psychiatric and social casework, group therapy, occupational therapy and educational lectures. When discharged, they were encouraged to visit the clinic as out-patients, to participate in Alcoholics Anonymous meetings and to utilise various social agencies (although aftercare facilities were limited in St. Louis at that time). There were 78 patients in the control group who were detoxified and treated as in-patients for from seven

to ten days. They were encouraged to join group therapy, lectures and other activities. For them, however, there was no aftercare.

Both groups benefited to some extent. Nineteen experimental patients were abstinent at follow-up at one year. Eighteen had had intensive contact with aftercare agencies. Of the control patients, three were abstinent. Twenty-four percent of the experimental patients were employed before treatment; 64% after treatment. Of the controls, 26% were employed before; 51% were employed after treatment. Twenty-four percent of the experimental patients were homeless before treatment, 7% after treatment. Twenty-two percent of the controls were homeless before, and 9% after. Living conditions were evaluated as better after treatment by 43% of the experimental patients and by 32% of the controls.

The detoxification centre in Washington, DC, was purpose-built and has 75 beds (Walley, 1972). The court is no longer involved in the management of alcoholic offenders there. There is such overcrowding in spite of the size of the facility that there often is space to keep a man for only 24 hours. The patients then can be sent to a similarly-sized facility outside the city for another two days. There is little coherence or consistency to such a treatment programme, and there is no chance to make future plans or to help the man to understand his difficulties and to become motivated to change.

Apparently the police are disenchanted with the system partly since the men often are off the streets only overnight (Nimmer, 1972). They are picking up less than one tenth of the number of men they used to arrest for drunkenness. The Washington, DC, police have not been educated about alcoholism as have the St. Louis police.

In the City of New York it has not been illegal to be publicly intoxicated (Goff, 1969). The charge of disorderly conduct had always been used to clean up the Bowery, New York's Skid Row area. As a test of whether being publicly intoxicated constituted disorderly conduct, 1,400 cases were represented by counsel in court with the result that only seven out of these cases were convicted. As a consequence, police were ordered to arrest only those who were genuinely disorderly. The Bowery arrests dropped dramatically.

The Manhattan Bowery Project, opened there in 1967, is another large-scale non-hospital detoxification facility with 48 beds which operates more successfully than the Washington one (Griffith, 1973). The men are picked up on the Bowery by special teams made up of a member of Alcoholics Anonymous and a plain-clothes policeman. As many men as the facility will hold are brought in, and the others then are subject to arrest as in the past. The admissions are entirely voluntary. In their second year of operations about 90% of the men approached agreed to go

to the centre. They are expected to stay for five days. Only 3% of their admissions walked out prematurely. After the first five years of operation, the project had had over 15,000 admissions, treating over 5,000 individuals. Over half of the patients had been referred for further help and aftercare.

As a result of needs recognised by the staff on the project, new facilities were started in conjunction with the project. An aftercare clinic was set up in the same building. Taking disulfiram at the clinic is a requirement for attendance so that the men are certain to be sober when they are coming regularly. In 1973 there was an average of 93 men attending each week. Bahr (1973) reported that 17 out of 100 out-patients were abstinent for at least three months. There was some improvement in physical health and longer time between drinking bouts in the others. There is a medical clinic now in the same building and a half-way house outside the area, as well as facilities run by other organisations which are also available to the Bowery men.

Fox et al (1972) asked whether the penal revolving door system is simply being replaced by a therapeutic revolving door system. At the Austin Detoxification Unit, a 10-bed locked facility in Boston with a minimum of medical staff, they reviewed 100 patients over two years starting in 1968. The patients had been screened initially in the emergency room of the Boston City Hospital.

The alcoholics who agreed were sent for a 10-day detoxification programme on an involuntary basis. The treatment consisted mainly of non-intensive group discussion. Contact between the unit and patients between admissions was encouraged, and readmission was readily available. Forty-one percent of the patients maintained some contact while they were sober. Of these, 16 were sober for six or more months (average time 12.9 months) and 15 had periods of three to six months sober. They concluded that treatment was helpful in breaking the revolving door.

Another encouraging study of the results of residential treatment took place in California (Coffler and Hadley, 1973). In 1973 arrests for drunkenness were still made in California although there was a trend toward allowing treatment instead of incarceration. Coffler and Hadley undertook to determine the extent of arrest recidivism following rehabilitation centre treatment and to compare the costs of treatment and imprisonment. They studied a sample of 713 men who had been sent to three Rehabilitation Centres (operated by the Los Angeles County Department of Health Services). Referrals to the centres came from other county hospitals, social services, and more than half of them from the Los Angeles Municipal Court. The length of stay was 90 days and was voluntary. When an individual was sent to a centre rather than to jail by the court, he would be required to serve his suspended sentence of 177 days if he was arrested within

12 months of the date of referral. The men in the sample had averaged eight arrests during the year before treatment. They averaged four arrests during the post-treatment year ($p < 0.001$). Their arrest rate was reduced by 47%. The cost of treatment was estimated to be a reduction from justice system costs of between 41 and 75%.

In Indianapolis an experimental treatment centre was opened in the county jail in 1970 (Pratt, 1975). First offenders charged with public drunkenness were given a choice of voluntary treatment. Second or more frequent offenders were sent to a Rehabilitation Centre mandatorily for 45 days with a subsequent three month probation. The treatment consisted of group discussions, alcoholism education, counselling and Alcoholics Anonymous meetings. There were places in a half-way house available where men could be helped with employment and making contact with their families. While on probation the men saw their probation officer weekly and were expected to attend Alcoholics Anonymous meetings regularly.

Of the 274 alcoholics treated in 1971, 51% were abstinent at the end of the probationary period as well as having made improvement in their employment status. Arrests for public drunkenness in Indianapolis declined from 7,600 in 1969 to 5,100 in 1971. The programme was terminated in 1972 and arrests for public drunkenness rose to 7,000 in 1972. Due to its success, the centre was

restarted in a new setting at the end of 1972. The only other changes made were that the probationary term at the end was extended to six months, the medical programme was increased, there was additional vocational placement and more half-way house facilities.

Canadian law relating to the drunkenness offender is being changed by areas as is the United States Law (Walley, 1972). In 1971, Ontario legislation was altered to allow police to take those found intoxicated in public to detoxification centres instead of arresting them. In 1972 there were two detoxification units in Toronto, one of 18 beds and the other of 14 beds. The men stay for 10 days maximum on a voluntary basis. There were plans to build more centres in the province in the next few years. As in many United States areas, when the detoxification units are filled, drunkenness offenders are processed through the legal system as formerly.

Peterson (1974) reported that a 30-bed detoxification unit in Toronto had had 4,000 admissions in the first 26 months it had been open, only 5% of whom needed acute medical attention.

The emphasis throughout North America in establishing new detoxification and treatment centres to help the alcoholic who has been arrested for drunkenness in the past is on non-medical facilities staffed largely by para-professionals with only a minimum of medical staff.

Most of the states and cities which have initiated alcoholism treatment programmes have produced little in the way of evaluation results as yet. Some of them are hoping for some conclusions shortly.

As well as local and district government projects, there has been considerable activity in the field of alcoholism for quite a long time by voluntary bodies. The work of Alcoholics Anonymous is widespread and well known and members of AA are employed either as paid workers or volunteers in most of the projects and facilities which have been established recently. Most programmes for alcoholics, both private and public, include attendance at AA meetings as part of their basic treatment. The work of the Salvation Army in the field is also important. In many cities the only treatment facilities for Skid Row alcoholics have been the Salvation Army detoxification units and residential hostels. They have been up-to-date with their non-medical treatment units in such large cities as San Francisco and Chicago where they have a 200-bed social service centre with a 90-day treatment programme.

CHAPTER 2

ESTABLISHMENT OF THE PROJECT

ESTABLISHMENT OF THE PROJECT

Detoxification in the United Kingdom is of course carried out at present in many different medical and non-medical settings - by general practitioners in their patients' homes, by casualty officers in hospitals' casualty departments, by physicians in general hospitals and in virtually all psychiatric hospitals. The voluntary services play their part such as the Cyrenians, in church crypts, night shelters and Salvation Army hostels. The DHSS reception centre at Camberwell, South London, was set up "to make provision whereby persons without a settled way of living may be influenced to lead a more settled life". Men who are drunk are allowed to stay in a waiting area till sober and are then admitted, and the centre sends out a van at night to pick up drunks from the street. The sick bay in the centre is used mainly as a detoxification area; there is no resident doctor.

In 1905 a National Congress on Prison Management was told that "no prison system yet devised has effected any improvement in the drunkard committed for the usual seven days or 14 days imprisonment" (Home Office, 1971). In 1967 Lord Stoneham, Minister of State at the Home Office, told the 'Habitual Drunken Offender' Working Party: "The work of drying up and cleaning up these men, well knowing that they will soon be back in prison is a stupid waste of

our badly strained prison resources" and the Chief Metropolitan Magistrate told them: "The habitual drunken offender represents an intractable and frustrating problem for the magistrate. His appearance in court enables society to register token disapproval but it achieves nothing constructive. None of the penalties available to the magistrate meets any of the normal criteria of sentencing policy. There is no evidence that imprisonment is a deterrent."

In recent years there have been moves to change the laws relating to public drunkenness in England and Wales.

The 1967 Criminal Justice Act had as part of its aims "to reform existing methods and provide new methods of dealing with offenders, to make further provision for the treatment of offenders". Section 91 increases the penalty for the offence of drunk and disorderly behaviour from £10 to £50 but at the same time removes the penalty of imprisonment for drunken offenders. However the Act also stated that a statutory order implementing these changes shall not be made "unless the Secretary of State is satisfied that sufficient suitable accommodation is available for the care and treatment of persons convicted of being drunk and disorderly". The Act does not apply to Scotland.

The 1972 Criminal Justice Act intended "to make further provision in respect to methods of dealing with offenders", and in section 34 provided police with the

power to arrest those drunk and incapable or drunk and disorderly, and "the constable may, if he thinks fit, take him to any place approved for the purpose of this section by the Secretary of State as a medical treatment centre for alcoholics".

It should be noted that section 91 of the 1967 Act will only affect the 16% of drunken offenders referred to previously who are sent to prison without the option of a fine, the other 84% going to prison due to non-payment of the fine. Indeed it could be the case, with the increase in the maximum fine, that in some areas where offenders are given no time to pay the fine more offenders could end up in prison.

In 1967 the Home Secretary set up a working party to "consider the treatment within the penal system, of offenders who habitually commit offences involving drunkenness, to assess the extent and nature of the need for such treatment, including the use and provision of hostels and to make recommendations". Their report (Home Office, 1971) reviewed the law relating to drunkenness, the extent and nature of the problem and its effect on the public, present treatment arrangements and took evidence from a wide range of statutory and voluntary bodies and individuals. Among its recommendations were the following:

1. "Some form of special arrangement for detoxification will be indispensable to any future system which attempts to deal comprehensively with public drunkenness."

2. "Persons who under present arrangements would be arrested for being drunk in public should be taken by the police to a detoxification centre, and there detained while they are detoxified and any necessary medical and social investigation is carried out."

3. "It is important that the detoxification centres themselves should be demonstrably medical and social work facilities with a clearly therapeutic purpose."

The report recommended the setting up of pilot detoxification units in cities with a significant number of habitual drunken offenders such as London, Birmingham, Nottingham and Liverpool. By 1975 however none had yet been established though there were plans for a detoxification unit in Manchester and discussions taking place in other cities in Scotland and England.

Responsibility for providing facilities for public drunks was passed to the DHSS in 1972 as part of a comprehensive treatment and rehabilitative service for all alcoholics (Department of Health and Social Security, 1973). The circular encouraged the formation of hostels and shop-front information centres, and financial assistance was made available to voluntary bodies to buy and run hostels. A minority view expressed in the Habitual Drunken Offender report was that the Government establish a commission for three years to implement the recommendations of the Working Party. The failure of detoxification centres to be established was criticised by the Campaign for the Homeless and Rootless (1974) and in September 1974 Dr. David Owen, the Minister of State at the DHSS, announced the formation

on Alcoholism
of an Advisory Committee/with a special sub-group specially charged with promoting the development of services for homeless alcoholics.

In 1965 a Scottish Home and Health Department report "Alcoholics - Health Services for their Treatment and Rehabilitation" discussing the pattern of future developments suggested that in large centres of populations certain of the acute effects of alcoholism "would be more suitably treated along with other forms of poisoning in a special poisons unit where this exists".

Sclare in 1969 suggested that detoxification centres "could be sited in urban areas either within large general hospitals, perhaps as an adjunct to an existing poisons centre, perhaps as a sub-unit of the casualty department or, less felicitously, as a separate facility".

Accordingly it was considered that the Regional Poisoning Treatment Centre (RPTC) which had been established in Edinburgh for several years (Matthew et al, 1969) might become an appropriate centre for detoxification of alcoholics. In addition to staff expertise in treating patients poisoned by a variety of agents, the unit, situated in the Royal Infirmary of Edinburgh, was in close proximity to the police headquarters and to the Grassmarket/ Cowgate area of the city, sometimes known as Edinburgh's 'Skid Row'.

A report covering the seven years 1968-74 (Holding et al, 1975) showed that in 62% of all male (age 15 and over)

admissions to the RPTC, alcohol had been taken at the time of the self-poisoning act with another drug. Thirty-four percent of all male admissions were drunk on admission. Forty-eight percent were considered to have a problem with alcohol (28% excessive drinkers, 14% alcohol dependent, 6% chronic alcoholics). The unit does not accept the routine detoxification of alcoholics but will admit those severely poisoned with alcohol if grade III unconscious (Matthew and Lawson, 1970). The Accident and Emergency Department of the Royal Infirmary, Edinburgh, also attends to a large number of drunks and alcoholics.

Discussions prior to the establishment of the project were held with the nursing and medical staff of the RPTC and Accident and Emergency Department and with the police authorities, including the Chief Constable, and with the Procurator Fiscal. They saw no insurmountable difficulties in introducing a detoxification service and pledged their support for the project. The prosecuting authorities were able to agree to waive their right to prosecute any subject taking part in this research project and rather than charge a man with being 'drunk and incapable', it was agreed that the patient would instead be brought direct to the detoxification unit. In the general order issued to all police in Edinburgh, the Chief Constable also asked police officers to use their discretion in apprehending a man who had committed another minor offence when drunk, and to take them also, if appropriate, to the detoxification unit.

CHAPTER 3

AIMS AND METHODS

AIMS AND METHODS

Aims of Project

The study had two principal objectives:

1. To assess the feasibility and effect of adding an alcohol detoxification service to an existing Regional Poisoning Treatment Centre, and to a psychiatric hospital.

2. To evaluate where possible the effectiveness of a detoxification, assessment and referral service for socially deteriorated alcoholics, with the nucleus of this service based on the detoxification centre.

After a year in the Regional Poisoning Treatment Centre, for reasons given later, the detoxification centre was transferred to a ward in a psychiatric hospital. The study then had the additional opportunity to compare the working of the detoxification centre within this alternative model.

Methodology

The criteria for enrolment into the study were (1) the patient should be male and (2) living in Edinburgh. He should be (3) suffering from alcoholism as defined by the World Health Organisation (1952)[1] and (4) should show some social deterioration as evidenced by a decline in occupation

[1] "Alcoholics are those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily and mental health, their interpersonal relations and their smooth social and economic functioning; or who show the prodromal signs of such development. They therefore require treatment". For discussion on how the definition was used in an operational context, see page 85a.

or marital status or in quality of living accommodation. He should (5) not currently be receiving treatment for alcoholism. He must have (6) had one conviction for a drunkenness offence within the previous 12 months and (7) at least one other similar conviction in his lifetime.

Women were excluded because of the lack of beds likely to be available for them in the RPTC.

The number of convictions for drunkenness decided upon was arbitrary but it was hoped that the cohort would then include some younger and less deteriorated individuals whom the project team could reasonably expect might respond somewhat better to rehabilitative measures than the older and more deteriorated habitual offenders.

All patients meeting the enrolment criteria were selected for the study until a total of 100 had been recruited.

The medical staff of the Regional Poisoning Treatment Centre, the Accident and Emergency Department at the Royal Infirmary, Edinburgh, and psychiatric staff of the Royal Edinburgh Hospital were invited to refer patients, as also were counsellors in the Edinburgh and District Council on Alcoholism, general practitioners practising in the Grassmarket/Cowgate area, wardens of hostels with resident alcoholics and local authority social workers. In practice it was found to be expeditious to recruit from the local Burgh Court, or prison to which offenders might be sent after an appearance at court.

Ten subjects were enrolled after referral from psychiatric colleagues, and one each from a casualty officer, a physician in the RPTC and one from a local authority social worker. Sixty-four were enrolled at court and 23 from prison.

The Edinburgh Burgh Court was used for most recruitment as there it was easiest to find men meeting the enrolment criteria. The court made available to the interviewer the previous records of those appearing charged with a drunkenness offence, so that previous convictions could be noted and the appropriate individuals approached for interview. All the men were seen after their court case had been completed, the interviewer having no influence on the disposal of the men by the court. They were interviewed either in the court building or given an appointment to see the interviewer at hospital or sometimes in the patient's home.

The interviewer on approaching a candidate for enrolment would introduce himself as "a doctor with an interest in people who get into trouble with the police because of drink".

Two individuals who were approached refused interview. Another two habitual drunken offenders who met the other enrolment criteria were found to be not alcoholics (as defined by the World Health Organisation, 1952) on interview. Four individuals did not keep appointments for the enrolment interview and were unable to be found later in their homes or lodgings.

Some individuals were unable (usually through brain damage) to answer all the questions in the enrolment questionnaire but these were not excluded from the study.

All subjects were therefore enrolled when sober. About a half were enrolled within 24 hours of their last court appearance for a drunkenness offence, and a further one-third within one week.

For two-thirds of the cohort the last court appearance for a drunkenness offence had been for being 'drunk and incapable', and a further one-quarter had been convicted of breach of the peace. The remaining 10% had been convicted for, whilst drunk, begging, vagrancy, being a nuisance, or a combination of two of any of these five types of offence.

The court appearance had resulted in 39% of the cohort being given a fine, which was paid, 31% were admonished, 27% went to prison in default of payment of a fine. Two percent went to prison without the option of a fine and one man was put on probation.

Enrolment continued during the course of a year until the 100 men required to complete the cohort had been enrolled.

On completion of each individual enrolment the patient was then randomly allocated to a proband or control group. This was done with the aid of a table of random numbers, odd digits indicating a control, and even digits a

proband. This provided 52 for the proband group and 48 for the control group.

The Controls

After the enrolment interview the individuals assigned to the control group were offered no treatment from the project team. They continued to be able to use the usual facilities existing in the city. They were told that the project team would like to keep in touch with them to ascertain their progress.

When word had spread among the men about the project, some men in the control group expressed disappointment at not being included in the proband group. Most accepted the explanation of the experimental nature of the project though one or two continued to ask the project team members in later months when they could be taken into the proband group.

The Probands

On completion of the enrolment questionnaire the probands were told the aims of the project and invited to attend an out-patient clinic to see the project psychiatrist and social worker for help with any problem. They were given a card which they were told meant that if they were found drunk they could be brought to the detoxification centre and would not be charged by the police with being drunk and incapable. The probands were told that the project team would like to see them regularly to monitor their progress.

The Cohort

The enrolment information taken by questionnaire from all subjects included details of their present and past accommodation, employment, marital status; their convictions for drunkenness, their medical history and of treatment for alcoholism; drinking history and incidence of symptoms and consequences of alcoholism (Appendix A).

The enrolment questionnaire was designed to demonstrate changes in the patients' marital status, employment status and accommodation, to confirm the diagnosis of alcoholism. At 12 months from the date of enrolment all subjects who could be traced were questioned on the same (and other) topics using a similar questionnaire. After a further six months more information on the progress of the subjects was obtained by studying court and prison records. Several studies have shown that progress during the first six months or year after treatment is a valuable guide to subsequent prognosis (Davies, 1956; Edwards and Guthrie, 1967; Ritson, 1968).

CHAPTER 4

CHARACTERISTICS OF THE SUBJECTS

CHARACTERISTICS OF THE SUBJECTS

The data obtained at the enrolment interview was recorded on coding sheets (Appendix A) and definitions are given in 'notes for coding' (Appendix B). Unless otherwise stated there were no statistically significant differences between the proband and control groups. In 2 measures probands and controls showed differences at $p<0.05$. In 53 measures there were no differences between the two groups.

The main studies with which the information obtained is compared are those of Edwards et al (1966) who investigated 51 regular male patrons of a soup kitchen in Stepney, London; Gath's (1969) study of 151 male drunken offenders appearing in two London courts, and Whalley's (1975) unpublished study of 50 consecutive admissions of alcoholics admitted to the Unit for the Treatment of Alcoholism in the Royal Edinburgh Hospital.

AGE

Table 4.1

AGE

Years	Cohort (N = 100) %	1971 Census Edinburgh Males (N = 211, 405) %
20-29	6	16
30-39	15	11
40-49	35	12
50-59	32	12
60-69	15	11
70-79	5	5

Table 4.1 shows the age distribution of the cohort. The mean was 48.6 years (standard deviation 11.6) on the subjects' last birthday, and the group are overrepresented in the 40-60 age group compared with the normal population ($\chi^2 = 17.5$; df = 5; $p < 0.01$). The age range was 21-75. The mean of 48.6 years compares with a mean of 44.7 (range 26-74) in Edwards' (op.cit.) study and with means of 39.4 and 44.0 (range 18-79) in Gath's (op.cit.) study and 44.1 years (standard deviation 10.7) in Whalley's (op.cit.) study.

The men in the cohort are younger than those of common lodging house residents. Priest (1971) in his study found 76% of 79 inhabitants of common lodging house residents in Edinburgh were aged 50 or over, compared with 52% in this study.

NATIONALITY

Table 4.2

NATIONALITY

Place of birth	Cohort (N = 100) %	1971 Census Edinburgh Males (N = 211, 405) %
Scotland	83	87
England and Wales	2	8
Northern Ireland	1	0.5
Irish Republic	13	0.5
Other	1	4

The place of birth of the subjects is shown in Table 4.2. Half the Scottish men were born in Edinburgh. The

Irish are overrepresented ($\chi^2 = 10.4$; df = 1; $p < 0.01$). The one 'other' individual was born in Poland. All individuals were Caucasians. In Edwards' (op.cit.) study 27% of the men were Scottish and 37% Irish, whilst in Gath's (op.cit.) study 13% were Scottish and 38% Irish. All Whalley's (op.cit.) men were Scottish. Priest (op.cit.) found 73% Scottish and 19% Irish.

MARITAL STATUS

Table 4.3

MARITAL STATUS

	Probands (N = 52) %	Controls (N = 48) %	Total (N = 100) %
Single	49	62	55
Married/Cohabiting	12	4	8
Divorced/Separated/ Living apart	33	27	30
Widowed	6	4	5
(Not known)	(1)	(0)	(1)

Two-thirds of those who had been married at one time showed breakdown of their marriage.

Table 4.4

MARITAL STATUS

	Cohort (N = 100) %	1971 Census Edinburgh Males age 20 years and over (N = 142, 920) %
Single	55	21
Married*	23	73
Widowed	5	5
Divorced	14	1
(Other and not known)	(3)	(0)

*Includes living apart, separated and cohabiting

Table 4.4 shows the overrepresentation of single men and those divorced compared with males of the same ages in the general population. In Whalley's (op.cit.) study only 14% were single, 50% living with their wives, and 28% were divorced, separated or living apart. Edwards (op.cit.) found 65% had never married, whilst Gath (op.cit.) found 56% single, 18% married and 22% with breakdown of marriage. Priest (op.cit.) found 66% single and Scott et al (1966) in their study, also of Edinburgh common lodging house residents, found 61% of 251 men were single and 23% with breakdown of marriage.

OCCUPATION AND SOCIAL CLASS

Table 4.5

SOCIAL CLASS

Class	Cohort (N = 100) %	1971 Census Edinburgh Males (10% sample N = 12,170) %
I	0	8
II	2	17
IIINM	3	14
IIIM	21	36
IV	14	16
V	60	9
I, II & III	26	75
IV & V	74	25

The usual occupation of the subjects was noted and coded according to the Registrar General's classification

(Office of Population Censuses and Surveys, 1970), and Table 4.5 shows the vast overrepresentation of those in unskilled occupations. Among those in the higher social classes were a teacher and a newsagent. There were four painter/decorators, an occupation known to have a high incidence of alcoholism (Hitz, 1973).

The social class of the subjects' fathers did not differ from the general population.

Table 4.6

SOCIAL CLASS OF SUBJECTS AND THEIR FATHERS

	Probands (N = 52) %	Fathers of Probands %	Controls (N = 48) %	Fathers of Controls %	All Subjects (N = 100) %	Fathers of all Subjects %
I	0	2	0	2	0	2
II	0	10	4	10	2	10
IIINM	4	6	2	6	3	6
IIIM	23	44	19	42	21	43
IV	8	11	21	13	14	12
V	65	21	54	25	60	23
(Not known)	(0)	(6)	(0)	(2)	(0)	(4)
I, II, III					26	64
IV, V					74	36

Table 4.7

SOCIAL CLASS OF SUBJECTS
COMPARED WITH THAT OF THEIR FATHERS

	Probands (N = 52) %	Controls (N = 48) %	Total (N = 100) %
Same social class	38	38	38
Fall in social class	50	52	51
Rise in social class	6	8	7
(Not known)	(6)	(2)	(4)

Tables 4.6 and 4.7 show the fall in social class of the subjects compared with their fathers.

It would have been advantageous to have noted the best and present occupations of the individuals to ascertain any downward drift. In Whalley's (op.cit.) study one-third of the subjects were in social classes IV and V, whilst in the present study and that of Gath (op.cit.) more than two-thirds were in these groups. The figures in the present study of 26% in social classes I, II and III with 74% in classes IV and V are identical to that found by Priest (op.cit.) and those for the fathers of the subjects in both studies correlated very highly.

EMPLOYMENT RECORDS

Table 4.8

WORK PERFORMANCE IN LAST YEAR

	Probands (N = 52) %	Controls (N = 48) %	Total (N = 100) %
Continuously employed	13	15	14
Employed 9-12 months	4	6	5
Employed 6<9 months	8	12	10
Employed 3<6 months	6	0	3
Employed <3 months	11	8	10
Continuously unemployed	58	58	58
(Not known)	(2)	(0)	(1)

Table 4.8 shows the employment records of the cohort in the 12 months prior to enrolment. Seventy-two percent were unemployed at the time of interview, 20% in full-time employment as seen in Table 4.9.

Table 4.9

EMPLOYMENT STATUS

	Probands (N = 52) %	Controls (N = 48) %	Cohort (N = 100) %	1971 Census Edinburgh Males age 20 years and over (N = 142,915) %
In employment*	21	21	21	75
Unemployed, sick, etc.	71	73	72	12
Retired	8	6	7	12

*Includes casual/seasonal

Twenty-five percent of the cohort had been unemployed for over five years at some time in their lives. The mean duration of longest unemployment was 4.9 years (standard deviation 7.1). Subjects were also asked for the longest period of work in their lifetimes. This period was up to five years in 42% of the cohort with 16% having 6-10 years, 22% 11-20 years and 19% having had over 20 years in work. The mean length of longest employment of the cohort was 11.8 years (standard deviation 11.8). The median length of longest unemployment was two years, and of longest employment seven years.

ACCOMMODATION

The Grassmarket is an old part of central Edinburgh in the shadow of the walls of Edinburgh Castle. In character it has changed little over the centuries; a memorial in the centre of the street marks the place of the last public execution in the city. The Grassmarket and Cowgate contain two large model lodging houses for men as well as a Salvation Army 'hostel' and a Church of Scotland night shelter; 2.4% of the Edinburgh population live in the area of the city which includes the Grassmarket (General Register Office, 1973).

In the year before enrolment 43% of the subjects had usually lived in the Grassmarket/Cowgate area of the city and 39% elsewhere in Edinburgh. The others had lived elsewhere in Scotland or Britain, or had spent most of

that year in prison or hospital. Forty-eight percent of the cohort had lived most of that year in a common lodging house or night shelter and a further 14% could be classed as homeless. The 38% with a home included 16% living in a corporation house, 6% owner occupiers, the rest in rented accommodation or 'digs'. Sixty-nine percent lived alone and Tables 4.10, 4.11 and 4.12 show the downward drift in the type of living situations from the type of accommodation they had lived in most of their lives.

Table 4.10

ACCOMMODATION

Type of premises

		Year before enrolment cohort %	Previous lifetime (from age 15 years) cohort %
'Homeless'	(Common lodging house, night shelter, sleeping out of doors, prison, etc.)	62	25
'Home'	(House, owned or rented, digs)	38	75

Table 4.11

Location

	Year before enrolment cohort %	Previous lifetime (from age 15 years) cohort %
Grassmarket/Cowgate	43	10
Other Edinburgh	39	44
Elsewhere	18	46

Table 4.12

	Persons living with: Year before enrolment cohort %	Previous lifetime (from age 15 years) cohort %
Alone	69	39
Wife	7	26
Parents	6	21
Others	18	14

PREVIOUS CONVICTIONS

In Table 4.13 it is seen that 67% of the subjects had been arrested up to five times in the year before enrolment; this contrasts with 50% in Gath's (op.cit.) though for those arrested more than ten times the figures are comparable (13% and 10% respectively).

Table 4.13

NUMBER OF COURT APPEARANCES FOR DRUNKENNESS OFFENCES IN YEAR BEFORE ENROLMENT

Number of appearances	Probands (N = 52) %	Controls (N = 48) %	Total (N = 100) %
1	15	21	18
2	8	15	11
3-5	42	33	38
6-10	19	21	20
11-25	14	8	11
26-50	2	2	2

Table 4.14

LIFETIME COURT APPEARANCES FOR DRUNKENNESS OFFENCES

Number of convictions	Probands (N = 52) %	Controls (N = 48) %	Total (N = 100) %
3-10	33	29	31
11-50	48	58	53
Over 50	20	12	16

Of the 16 individuals in Table 4.14 with over 50 lifetime convictions for drunkenness offences, seven had over 100, including one with over 200 convictions. Forty percent of the cohort had had no convictions for offences other than drunkenness, 30% had one to five and 30% over five such convictions, commonly for assault or petty theft.

ALCOHOLIC HISTORY

Symptoms of addiction to alcohol

Table 4.15

SYMPTOMS OF ALCOHOLISM

	Probands (N = 52)			Controls (N = 48)			Total (N = 100)		
	positive	% never	(not known)	positive	% never	(not known)	positive	% never	(not known)
Morning shakes	83	17	(0)	71	27	(2)	77	22	(1)
Alcoholic amnesias	94	6	(0)	96	4	(0)	95	5	(0)
Fall in tolerance	63	31	(6)	69	25	(6)	66	28	(6)
Delirium tremens	56	40	(4)	33	62	(4)	45	51	(4)
Alcoholic hallucinosis	29	67	(4)	23	69	(8)	26	68	(6)
Withdrawal fits	2	92	(6)	12	82	(6)	7	87	(6)

The subjects were questioned as to their experience of the various symptoms of chemical dependence on alcohol. Gath (op.cit.) also found a higher incidence of alcoholic amnesias (79%) than morning shakes (62%), whilst Edwards et al (1967) in their study of 100 clients of alcoholic information centres in Glasgow, Gloucester and Liverpool found an identical figure to the present study of amnesias in 95%, and 90% had experienced morning shakes. Among Edwards' (1966 op.cit.) Skid Row men 80% had had amnesias and 90% shakes. Seventy percent of Whalley's (op.cit.) hospital alcoholics gave a history of amnesias and 86% of shakes. Seventy-eight percent in the present study admitted to morning drinking at some time; this compares with 50% of Gath's (op.cit) offenders and 76% of Edwards' (1966) alcoholics.

In the present study about half the cohort had experienced delirium tremens. Probands had experienced DT's more often than controls ($\chi^2 = 4.30$; $df = 1$; $p < 0.05$).

Twenty-six percent of Whalley's (op.cit.) hospital alcoholics had experienced delirium tremens and 60% of Edwards' (op.cit.) Skid Row men. Thirty-seven percent in the present study had experienced auditory hallucinations and 38% visual hallucinations, some both. Seven percent knew that they had had fits during withdrawal from alcohol.

Two-thirds admitted to a fall in tolerance but despite careful questioning by the interviewer there was sometimes doubt that the phenomenon did exist in some individuals.

It was stated earlier (page 68) that one of the enrolment criteria was that each subject should be suffering from alcoholism as defined by the World Health Organisation (1952). This definition has limited usefulness in an operational context and for the purposes of this study it was decided that each individual should have the generally accepted symptoms of physical addiction to alcohol manifested either by evidence of having experienced the withdrawal syndrome or of tolerance to the effects of alcohol. In the case of the former any one of the following symptoms was sufficient to make the diagnosis: morning tremors, delirium tremens, withdrawal fits or alcoholic hallucinosis. In the case of change in tolerance the diagnosis would be made on evidence of fall in tolerance or of alcoholic amnesias together with other strong supporting evidence of the person being alcoholic such as morning drinking.

Using these operational criteria, the following results were obtained:

77 subjects had experienced morning shakes, all with one or more of the other symptoms mentioned above;

3 had experienced delirium tremens, all together with other symptoms but denying ever having experienced morning shakes;

2 had had withdrawal fits and had also experienced amnesias and fall in tolerance;

18 had not experienced withdrawal symptoms but admitted

to combinations of at least two of alcoholic amnesias, fall in tolerance, or morning drinking.

There is no uniform agreement amongst those specialising in alcoholism on diagnostic criteria; these include physiological aspects of addiction, medical complications, and aspects of psychological dependence. It is likely, however, that most would agree that those showing signs and symptoms of physiological dependence are alcoholics. As indicated above, this was the case in all of the cohort.

It can be added that there was always further evidence to support the diagnosis of alcoholism such as multiple arrests for public drunkenness, drinking most days of the week, having lost employment through drunkenness, regularly drinking alone or out of doors, consuming cheap wine or crude spirits, or having had physical complications of alcoholism.

Table 4.16

AGE WHEN FIRST TOOK A DRINK

Age (years)	Probands (N = 52) %	Controls (N = 48) %	Total (N = 100) %
14 or less	10	8	10
15, 16, 17	39	42	40
18	25	21	23
19-25	25	21	23
26-35	2	6	4

Fifty percent of the cohort had first bought or been bought an alcoholic drink before the legal age to purchase the same, as seen in Table 4.16. This is about three times the rate in the general population, according to data in a report on drinking habits in Scotland (to be published in 1976):

Table 4.17

AGE AT FIRST DRINK

Age first took a drink (years)	Scottish males %	Cohort %
Less than 18	16	50
18	18	23
19-25	41	23
26+	13	4
Never	12	0

It is also seen that only half as many in the cohort as in the general population started drinking after the age of 18.

Each individual in the present study was asked how long ago he had started drinking regularly, lost a job through drinking, etc. It has not been possible in the present study to use the data to define common paths of progress through the course of alcoholism and relate this to the age of each individual.

Table 4.18

PROCESS OF ALCOHOLISM

Number of years since	% of cohort* Never or up to 10 years	10 years and over
First got drunk	3	97
First started drinking most days	22	78
First arrested for drunkenness	28	72
Drink started interfering with life	31	69
First in prison for drunkenness	44	56
First lost a job through drink	60	40
First had alcoholic amnesia	62	38
First had morning shakes	71	29
First had delirium tremens	84	16

*(Excluding missing data: if included does not affect order or any figure by more than 5%)

However Table 4.18 seems to indicate a natural course of events resulting from heavy drinking and progressing to alcohol addiction. Edwards (op.cit.) found his Skid Row men showed the following milestones:

	Average age (years)
Drinking regularly	18.2
Drinking most days	23.6
Drink a problem	29.0
First drunk arrest	29.3
First imprisonment	33.5
On Skid Row	38.0

Circumstances of drinking

Fifty-one percent of the cohort said they usually drank in public houses and 4% at home. The rest, 45%, said they drank 'outside' (19%) or 'anywhere' (26%). Nearly all those who drank in public houses habitually took beer and/or spirits, those who took wine and/or non-beverage alcohol drank 'outside' or 'anywhere'.

Half the subjects said they usually drank alone, the others with special drinking companions, friends or 'anyone'.

Type of alcohol consumed

Information from subjects was coded as to the type of alcohol they usually preferred to drink.

Table 4.19

TYPE OF ALCOHOL TAKEN

	Probands (N = 52) %	Controls (N = 48) %	Total (N = 100) %
Beer only	6	27	16
Spirits only	8	6	7
Wine only	33	15	24
Beer & spirits	23	35	29
Wine & crude spirits	15	4	10
Other mixed drinks	15	13	14

Wine means fortified 'British' wine of sherry or port type costing in 1973-74 about 50p per bottle.

Those in the 'other mixed drinks' category were found to consume wine or crude spirits together with beer or beverage spirits and thus the cohort splits into 52% who drank beer and/or spirits, and 48% who drank wine and/or crude spirits, perhaps taking beer or spirits if available. This latter group really drank 'anything'. This compares with 58% who did and 42% who didn't drink crude spirits among Edwards' (op.cit.) study of Skid Row men in London.

The crude spirits taken was a substance known as 'Bel-Air', a cheap liquid refill bottle of women's hair lacquer. Its attraction, besides its price (7-10p) is its availability, as not being classed as an alcohol product it can be bought from newsagents and other 'corner shops' outwith licensing hours. It has a particularly vile taste and smell, and users customarily dissolve the liquid in a bottle of wine or cider (which it turns milky white).

The proband and control groups differed in their use of wine and crude spirits, 63% of the probands habitually consuming wine compared with 32% of the controls ($\chi^2 = 9.12$; df = 1; $p < 0.01$), and this represents the main difference between the two experimental groups. It is suggested that the other differences significant at the 5% level - incidence of delirium tremens and classification of type of alcoholism - are related to this higher incidence of consumption of 'anything alcoholic'.

Periods of abstinence

Table 4.20

LONGEST ABSTINENCE

in the year before enrolment

	Probands (N = 52) %	Controls (N = 48) %	Total (N = 100) %
Less than 1 day	17	10	14
2 - 6 days	36	34	35
1 - 4 weeks	19	26	23
1 - 4 months	17	23	20
Over 4 months	10	2	6
(Not known)	(0)	(4)	(2)

Subjects were asked for the longest period they had been completely without alcohol in the 12 months prior to enrolment, excluding enforced abstinence, e.g. through imprisonment or hospitalisation. Figures are not available for comparison with the general population but the figures of nearly half going over one week, and a quarter over one month, seem higher than might be expected.

Type of alcoholism

Table 4.21

TYPE OF ALCOHOLISM

	Probands (N = 52) %	Controls (N = 48) %	Total (N = 100) %
Loss of control	62	40	51
Inability to abstain	15	31	23
Bout drinker	10	4	7
Other	13	21	17
(Not known)	(0)	(4)	(2)

Half the subjects were classified as Jellinek's (1960) 'loss of control' (gamma) type and the incidence amongst the probands is slightly higher ($\chi^2 = 3.98$; df = 1; $p < 0.05$). The relative incidence of 'loss of control' coincides with 49% found in Gath's (op.cit.) study though 24% of his cohort were not found to have a problem with other alcohol. In Edwards' (1966) study 96% of the men were thought to be 'gamma' alcoholics.

PHYSICAL COMPLICATIONS

Table 4.22

PHYSICAL COMPLICATIONS

	Cohort %		
	Yes	Never	(Not known)
Peripheral neuritis	51	48	(1)
Gastritis	46	53	(1)
Peptic ulcer	18	80	(2)
Liver cirrhosis	14	75	(11)
Organic brain disease	5	82	(13)

Table 4.23

INJURIES

	Cohort %		
	Yes	Never	(Not known)
From physical assault	67	31	(2)
Traffic accident	40	59	(1)
Industrial accident	20	79	(1)
Other accident	15	84	(1)

Subjects were asked if they had ever had any of the medical conditions given in Table 4.22. Peripheral neuritis and gastritis were diagnosed by their symptomatology and in the case of peptic ulcer, liver cirrhosis and organic brain disease subjects had been told they had the condition. No attempt was made to investigate the subjects to establish a diagnosis nor were any medical records specially perused to this effect.

The 18% with peptic ulcer corresponds to 16% in both Gath's (op.cit.) male offenders and Edwards' (op.cit.) Skid Row men. The high rate of injuries from assaults and accidents also agrees with the findings of these two authors: among Gath's offenders 26% had had serious head injury, and 18% in Edwards' study had had severe fractures or loss of limbs.

FAMILY HISTORY

Table 4.24

FAMILY HISTORY OF ALCOHOLISM

	Yes	No	Cohort % Not applicable	(Not known)
In father	41	56	-	(3)
In mother	4	92	-	(4)
In sibling(s)	23	64	6	(7)
In child(ren)	4	22	73	(1)
In wife	3	30	66	(1)
In cohabitee	2	0	98	(0)

To code a parent or relative as alcoholic the interviewer probed at some length to be satisfied that the person in question was dependent on alcohol and would probably meet the criteria of the World Health Organisation (1952) definition. Individuals seemed more willing to say their fathers were alcoholic than their mothers and as there was no check on these figures they must be held to be of doubtful reliability.

Table 4.25

HISTORY OF SEPARATION FROM PARENTS

	Cohort % Yes, before age 10 years	Yes, age 10-15 years	No	(Not known)
From mother	10	10	79	(1)
From father	15	8	76	(1)

Each individual was asked whether he had been permanently separated from one or both parents during childhood. The number of subjects who had been separated

from one or both parents in childhood was 25. Of these five had been separated from father only before age 10 years, eight had been separated from both parents before 10, and seven from both parents between ages 10 and 15.

Twenty-three men had one or both alcoholic parents from whom they were not separated, nine were separated in childhood from their (non-alcoholic) parents, and 16% had both an alcoholic parent and were separated. Thus 48% of the cohort were brought up in a situation where one or both parents were missing or were alcoholic (assuming that the parents were alcoholic when the individual was a child). This high figure supports theories on causes of alcoholism (Straus, 1946; Pittman and Gordon, 1958; Lisansky, 1960) but is, as has been stated, of unproven reliability.

Thirty-nine percent of the cohort had an alcoholic parent and this compares with 35% with a family history of alcoholism in Vallance's (1965) study of 68 male alcoholics in a Glasgow hospital.

Edwards (op.cit.) found that 58% of the men in his study had been during childhood (before age 13) deprived of a continuing relationship with one or both parents for a period of three or more years. Munro (1965) however showed that in a psychiatrically normal population 20% of the population have lost a parent through death before the age of 16, and 47% through death and other causes of separation.

PSYCHIATRIC DIAGNOSIS

Fifteen percent of the cohort said they had had psychiatric treatment other than for alcoholism as an in-patient in a psychiatric hospital, and 14% as an out-patient. It was not always clear that such treatment was not for alcoholism, e.g. a man would say he was being treated for 'nerves' when it seemed clear he was alcoholic at the time.

An attempt was made to apply a psychiatric diagnosis at the enrolment interview. The circumstances of the interview situation were however far from ideal - usually being conducted at the end of a cold dark corridor in the court building with a man feeling 'the morning after' and anxious to leave. Only obvious psychiatric disorder was noted. In addition to personality disorder, five men were thought to have organic brain disease, three schizophrenia, two severe psychoneurosis and one depressive illness.

Abuse of drugs

Eighty-five percent of the cohort denied ever taking drugs other than those prescribed. Thirteen (five probands and eight controls) had taken drugs, six in the last 12 months. None (to our knowledge) were registered drug addicts. Experimental drug taking was more common in Edwards' (op.cit.) London men but he also found that when asked about drug taking many men expressed fiercely moralistic views.

Parasuicide

Twenty-five percent of the cohort had been admitted to hospital because of attempted suicide at least once in the past, and a further 7% had attempted suicide but had not been hospitalised. Gath (op.cit.) found 8% and Edwards 20%.

SELF PERCEPTION OF BEING AN ALCOHOLIC

Sixty-two percent of the cohort admitted they were alcoholics, 34% denied they were and 4% gave a reply which could not be categorised as yes or no. The question asked was, "Are you an alcoholic?" and if asked to elaborate the interviewer asked if the man thought he had a serious drink problem. Hershon et al (1974) in their study of 132 drunkenness offenders in a London court found about one-third being sure they were alcoholics, about one-third being sure they were not and the last third answering otherwise. The number in their study however who were alcoholics is not known whereas in the present study all are considered to meet the criteria for a diagnosis of alcohol addiction.

TREATMENT FOR ALCOHOLISM

Fifty-six percent of the cohort had received no treatment for alcoholism. Forty-two percent had been given some form of treatment, 2% not known. The subjects were asked if they had any kind of medical treatment for their drinking, or help from any other person or body such as Alcoholics

Anonymous or an alcoholism counsellor. Of the 42 who had received treatment, 30 had been given treatment by a psychiatrist, two by their general practitioner and the others by a combination of various treatment agencies.

The figure of over one half having had no treatment whatsoever is striking in view of the severe and chronic nature of their alcoholism. Fourteen of the 51 men in Edwards' (op.cit.) study stated they had attempted to get treatment in the past and been refused. In Hershon's (op.cit.) study 28% had received psychiatric treatment for alcoholism or attended Alcoholics Anonymous meetings.

CORRELATIONS OF DATA

Fifteen items from the data obtained on enrolment from the entire cohort were used to find simple correlations. The items used were:

1 Age: 3 groups: young (21-39 years) (21% of cohort), mid-age (40-49 years) (59%), old (60-75) (20%)

2 Marital status: 3 groups: single (55%), married or cohabiting or widowed (15%), divorced, separated or living apart (30%)

3 Duration of change in marital status

4 Accommodation in year before enrolment: 2 groups:
homeless (common lodging house, night shelter, sleeping out of doors, hostel, hospital or prison) (62%)
home (digs with or without board, corporation house, rented house or owner occupied) (38%)

5 Usual accommodation in lifetime from age 15 to year before enrolment (as above - 27% and 72% respectively)

6 Social class: 2 groups: social class I to IV inclusive (40%) and social class V (60%)

7 Present employment status: 2 groups: unemployed (80%) in work (20%) together with duration of that state in three groups - short time (up to one year), medium time (1-5 years) and long time (6 years and over)

8 Work performance in last year: 2 groups: worked (42%), continuously unemployed (58%)

9 Court appearances for drunkenness offences in the last year: 2 groups: one or two offences (29%), three or more (71%).

10 Total court appearances for drunkenness offences in lifetime: 2 groups: 3-10 offences (31%), 11 or more (69%)

11 Previous treatment for alcoholism: 2 groups: some (42%), none (56%)

12 Attempted suicide: 2 groups: never (67%), ever (32%)

13 Experience of delirium tremens: 2 groups: ever (45%), never (51%)

14 Type of alcohol consumed: 2 groups: beer and/or spirits (52%), wine and/or other drinks (48%)

15 Self perception of being an alcoholic: 2 groups: positive (62%), negative (34%)

The following is a summary of the statistically significant correlations found:

Ia Those who drank wine were likely to have experienced delirium tremens (DT's) ($p<0.001$), be unemployed ($p<0.01$), to accept that they were alcoholic ($p<0.05$), have had previous treatment for alcoholism ($p<0.05$), have the higher number of arrests in their lifetime for drunkenness offences ($p<0.05$), and not to have worked in the last year ($p<0.05$)

b Those who had previously experienced DT's were very likely to be wine drinkers ($p<0.001$) had attempted suicide ($p<0.001$), have had previous treatment for alcoholism ($p<0.001$), and accept that they were alcoholics ($p<0.005$)

c Those who accepted they were alcoholics were not surprisingly those who had had treatment ($p<0.001$), attempted suicide ($p<0.001$), had DT's ($p<0.005$) or be wine drinkers ($p<0.05$)

d To have had treatment for alcoholism it looked as though a man would have attempted suicide ($p<0.001$) had DT's ($p<0.001$), had breakdown of his marriage ($p<0.005$) or be wine drinkers ($p<0.05$). Those who had had treatment were likely to accept they were alcoholics ($p<0.001$)

IIa Those who had been homeless most of their lives tended to be those who had the higher number of lifetime arrests for drunkenness ($p<0.05$) and to have received no treatment for alcoholism ($p<0.05$)

b Those who were homeless in the last year had been homeless most of their lives ($p<0.05$). They were very likely to be of social class V ($p<0.0005$), wine drinkers ($p<0.001$), be 60 or over years old ($p<0.005$) and to have been idle in the past year ($p<0.01$)

IIc Those who had not worked in the last year were very likely to have been homeless ($p<0.01$) and to have had the higher number of drunkenness arrests ($p<0.01$) that year. They tended to be older ($p<0.05$) and wine drinkers ($p<0.05$)

d Those in social class V had been homeless in the last year ($p<0.0005$) and most of their lives ($p<0.001$) and to have the higher number of lifetime arrests for drunkenness ($p<0.005$)

e The highest number of lifetime arrests for drunkenness was found in those who drank wine ($p<0.05$), in social class V ($p<0.05$) and who had been homeless in the last year ($p<0.01$). The relationship between higher number of lifetime arrests and higher number of arrests in the last year was significant at $p<0.05$

There appear then to be two main constellations of interrelated phenomena:

(1) Wine drinking, experience of DT's, parasuicide, previous treatment for alcoholism and acceptance of being an alcoholic.

(2) Low social class, homelessness, unemployment and higher number of arrests for drunkenness.

These two constellations of mainly (1) alcoholic phenomena and (2) demographic phenomena seem fairly distinct, only the drinking of wine being common to any extent in both groups. The two constellations do not comprise separate groups of patients. It seems apparent that in the first group wine drinking results in a man having delirium tremens, being unemployed, attempting suicide, receiving treatment and

accepting he is an alcoholic. Homelessness is naturally associated with unemployment and low social class and those not working and without a home are likely to have a higher record of drunkenness arrests.

SUMMARY

It is not possible to present a profile of a typical male alcoholic habitual drunken offender living in Edinburgh. There are however many common characteristics. The man is likely to be aged 40-60 and be born in Scotland. If not single, his marriage is likely to have broken down. He is probably in social class IV or V and of lower social class than was his father. He is probably unemployed and has not worked in the last year. In his lifetime he is likely to have had long spells of unemployment and his longest period in work would be less than 10 years.

About half the men live in the Grassmarket/Cowgate area of the city, usually living alone in a common lodging house or night shelter, though such a man in his previous life probably lived with his wife or parents in a home elsewhere in Edinburgh or outside the city.

In the last year he has probably had 2-10 convictions for drunkenness offences and in his life a total of 6-50. He may or may not have had convictions for non-drunkenness offences.

Being alcoholic he will show symptoms of dependence but may or may not have experienced delirium tremens. He appears to have become addicted to alcohol at least 10 years ago and since then to have been repeatedly arrested for drunkenness. He will have lost jobs through drink, been in prison for drunkenness and at some time drank in the morning to 'get rid of the shakes'.

About half the men seem to drink beer and spirits in public houses, the others wine or 'anything' outside. About half the men appear to be of the 'loss of control' type.

If one of his parents was not an alcoholic, then it is possible that he was permanently separated from one of them during childhood. He will not abuse drugs. He is likely to show some physical damage from drinking and to have been assaulted or involved in an accident. He may well see himself as an alcoholic but more than likely has never had any treatment for his alcoholism.

CHAPTER 5

THE DETOXIFICATION PROGRAMME

THE DETOXIFICATION PROGRAMME

ADMISSION PROCEDURE

On enrolment patients were given a yellow card (Appendix C) entitling them to use the detoxification facility when intoxicated. If found drunk in the street, the police would bring a proband patient direct to the detoxification centre if they found the card in the man's possession. If he had no card, the man's name would be checked against an updated list kept in each of the Edinburgh police stations. On arrival at the hospital the police would be given a 'receipt' (Appendix D) for the patient, signed by the duty doctor or nursing officer to whom the police handed over the man.

If the man referred himself he would, on arrival at the hospital, have his name checked against the same list. It was not considered advisable to limit admission to those initiated by the police as it was thought that men who sought to have themselves dried out should not be in a more unfavourable position than those picked up by the police. It was recognised from the start that those referring themselves might 'abuse' the facility in that they might refer themselves when not drunk; however it was considered that if such patients were not admitted they might attempt to be lifted by the police. It was decided therefore to proceed with both types of referral and to monitor the

consequences. The procedure subsequent to entering the hospital differed in the two models used.

At the Royal Infirmary, Edinburgh, the man would wait in the Accident and Emergency Department until seen and examined by a casualty officer. If the physical examination revealed any other medical or surgical disorder the patient would be dealt with in the appropriate way, otherwise he would be transferred directly to the Regional Poisoning Treatment Centre (RPTC). There he would be bathed by the nursing staff and put to bed to sleep until the following morning.

At the Royal Edinburgh Hospital the man would be taken by a nurse directly to the Andrew Duncan Clinic / where he could if necessary lie on a stripped-down bed until in a fit state to be bathed. When put to bed after this, the duty psychiatrist would be called to examine the patient physically. He would then be left until morning.

On arrival the men were often dishevelled and very dirty in appearance and sometimes incontinent of urine or faeces. Their clothes had sometimes to be disinfested, other times destroyed. Sometimes these were replacement (though not new) clothes which the patients had been given by the ward a few days previously. Some men would curse and swear, and make the job of the nurses difficult unless they reacted to him in a good humoured and objective manner.

Alcoholics Anonymous (AA) offered their services in helping with the handling of men on admission but the medical

and nursing staff in the RPTC found insurmountable objections to their presence in the ward. They were however welcomed in the Andrew Duncan Clinic (ADC) where their help was appreciated by the nursing staff. On being notified by a telephone call from the police headquarters that a patient was being brought to the hospital, the nursing staff would telephone an AA member 'on call' (a list for every day being kept in the ward) who would come and either help with the management of the patient or sit by him after he was put to bed until he was asleep. The AA member would usually call the next day to enquire after the patient and possibly invite him to attend a meeting of the fellowship. These arrangements were not always satisfactory due to the differing expectations of the nursing staff and the individual AA member, but discussions took place with those concerned and difficulties were quietly ironed out.

It was found that most patients admitted during the evening did not require sedation until the following morning when this would be prescribed, if indicated, by the project psychiatrist. If admitted and needing sedatives during the day, this would be done by the junior doctor on the ward or by the project psychiatrist. In the evening if sedatives were required the doctor on call for the project would likewise prescribe. In the RPTC and the ADC problems requiring a doctor were dealt with, if not by the junior ward doctor, by one of the senior doctors 'on call', a list being kept in the ward for this purpose. In both

hospitals the project psychiatrist and the two other consultant psychiatrists of the project team were on this rota: in addition, in the RPTC, senior and junior physicians volunteered their services for the rota.

A permanent notice informed the nursing staff that a senior doctor on call should be contacted in the event of a change in the patient's medical condition, such as deteriorating level of consciousness, colour of the patient (e.g. cyanosis), abnormal temperature, pulse rate, respiratory rate or blood pressure; vomiting which persisted and caused concern; and patients difficult to manage, e.g. becoming unduly aggressive.

PRESCRIPTION OF SEDATIVES

The sedatives used to combat the patient's alcohol withdrawal symptoms varied with individual doctors but in general in the RPTC chlorpromazine was used, and in the ADC chlormethiazole.

The literature on the use of various drugs in the treatment of the alcohol withdrawal syndrome is extensive and includes studies on phenothiazines, benzodiazepines, barbiturates and butyrophenones among many others but few studies have been controlled.

Ban et al (1965) compared chlorpromazine and chlordiazepoxide and found both drugs beneficial in

preventing and controlling the withdrawal syndrome, but chlorpromazine acted faster and was less erratic. Chlorpromazine was thought to be more consistent towards the symptoms of hostility, suspicion, aggressiveness and insomnia, whilst chlordiazepoxide was more effective in reducing tremor and in improving food and fluid intake.

Kaim et al (1969) in a double-blind controlled study found chlordiazepoxide appeared to be the drug of choice in the prevention of delirium tremens and convulsions, and chlorpromazine was associated with the highest incidence of both.

Glatt et al (1965) found chlormethiazole brought relief from withdrawal symptoms in twice as many patients as in a placebo group. The authors were of the opinion that chlormethiazole should not be continued for longer than six days in view of the possible risk of dependence.

Madden et al (1969) compared chlormethiazole with a combination of trifluoperazine and phenytoin in a double-blind study, and found the drugs had similar rapid effects on the overall clinical condition of the patient. Following alcohol withdrawal, anxiety, depression, headache, 'subjective epigastric quivering', nausea and anorexia were significantly more common in patients receiving chlormethiazole. However in the opinion of the authors "the sleep inducing property of chlormethiazole makes it the preferable treatment for in-patients (although caution is needed in the presence of bronchial infection)".

In the detoxification programme the merits of the various drugs were discussed at meetings of the project team, the ward doctors and the nursing staff, and much importance was laid on the views of the latter. In general the medically trained nurses in the RPTC preferred to give injections of chlorpromazine, a drug with which they were familiar in the treatment of disturbed poisoned patients. The ADC nurses were more confident in the use of (oral) chlormethiazole.

The dose of chlorpromazine routinely prescribed was 100 mg. 2-8 hourly, either orally or by intramuscular injection when indicated. Chlormethiazole was given at the ADC in the following schedule:

First day	1.5 g. qid	(total 6 g.)
Second day	1 g. qid	(total 4 g.)
Third day	0.5 g. qid	(total 2 g.)
Fourth day	0.5 g. tds	(total 1.5 g.)
Fifth day	0.5 g. bd	(total 1 g.)

The patient would then ideally have no drug on his sixth day, prior to leaving the detoxification centre on the seventh day. The nursing staff would monitor the withdrawal symptoms of the patient and record the presence of these on a specially designed form (Appendix E). The signs and symptoms to be noted included pyrexia, tachycardia, sweating, tremor, agitation, disorientation, hallucinations, convulsions and insomnia. These were defined on a paper kept in the nurses' duty room (Appendix F).

PHYSICAL INVESTIGATIONS AND OTHER PROCEDURES

A form was also completed on each admission (Appendices G, H) with details of the date, day and time of admission, the source of referral, whether the admission and stay was voluntary or compulsory, why the patient was admitted, and when he was last discharged. Also noted was disturbance in conscious level and if so its duration, presence or absence of a list of withdrawal symptoms, the treatment given, and the length of stay.

Routine investigations were done on a patient's first admission and every six months thereafter if previously normal (Appendix I). The routine investigations were urine analysis, body weight, X-ray chest and skull, haemoglobin, white blood count, ESR, liver function tests, serological tests for syphilis, blood urea and electrolytes, and ECG. Other investigations were done when indicated.

When the patient agreed to participate in the project, a letter was sent informing his general practitioner. After each admission a letter was sent to the GP with details of the admission and any unusual features that needed to be brought to his attention. On completion of the patient's year in the study the GP was again informed. Many of the patients were on the 'temporary' list of doctors in the University Department of General Practice whose premises were in the Cowgate close to the common lodging houses where many of the patients lived.

METHODS OF ASSESSMENT AND REFERRAL

While the patient recovered from his drinking bout he would be seen daily by the project psychiatrist and social worker. In the RPTC the psychiatrist saw the patients in the early morning to present a report on each patient at the ward round conducted by the physician in charge of the RPTC. The psychiatrist and social worker would, together with the nursing staff, later decide with the patient what further management was most appropriate on that particular occasion.

The original aim was to keep each patient for a week in the detoxification ward, but as will be seen this was not always possible. At the ADC patients were encouraged to attend occupational therapy and when possible simple group discussions with the patients were held. The focus was on the 'practical' side; what had the patient been doing since he was last seen, where had he been living, what had contributed to his relapse? There was no facility for any psychiatric treatment in the RPTC.

The social worker and nurses would try to meet the day-to-day needs of the man, such as providing him with clean clothes or shoes, a walking stick, arranging dental treatment, social security appointments or to see an optician.

The facilities for rehabilitation of alcoholics in Edinburgh at the time the project was operating were extremely meagre. The Royal Edinburgh Hospital accepted some men to the general psychiatric wards but consultants varied in their willingness to admit the project patients. The Unit for the Treatment of Alcoholism, located in the same hospital, catered for those alcoholics with a good verbal ability, a past history of ability to make relationships and a lack of psychopathic traits. These characteristics were not to be found in many of the cohort. There did exist two hostels, one (Rankeillor Street) run by the Church of Scotland and which provided residential facilities for ex-prisoners, alcoholics and the like. The other (Vanburgh Place) was managed by a recovered alcoholic who was not popular with some patients in view of his belief that the answers to their problems could be found in the Bible.

THE GRASSMARKET PROJECT

Midway through the time the project was operating a hostel specifically for the rehabilitation of male alcoholics opened in Edinburgh (Thornybauk). It was managed by a team known as the Grassmarket Project, financed jointly by Edinburgh Corporation Social Work Department and an Urban Aid grant. In addition to establishing and running a hostel, the first of its kind in Scotland (and only the second in Britain), the

Grassmarket Project team investigated conditions at the local common lodging houses, encouraged Grassmarket residents to form tenants' associations and other similar activities.

The project psychiatrist was a member of the appointments panel for the Grassmarket Project social worker and hostel warden. He also, along with one other consultant psychiatrist from the project team, was a member of the management committee of the hostel. A local GP provided medical care for the hostel residents. Thornybauk hostel was open to referrals from all sources and the Detoxification Project had no special privileges in this respect. It should however be pointed out that the two teams worked together in many ways and a representative of the Grassmarket project attended regular meetings of the Detoxification Project team. In addition the psychiatrist attached to the detoxification team conducted weekly group meetings with all the residents in the hostel. The format and content of these have been discussed elsewhere (Edinburgh Corporation Social Work Department, 1974), together with the observations of the other psychiatrist who was a member of the hostel management committee, and the project social worker who made referrals to the hostel.

ARRANGEMENTS FOR FURTHER MANAGEMENT

Patients could then be referred, and perhaps admitted to a hospital or hostel. If medical or surgical treatment of any kind was indicated, they would be transferred to the appropriate hospital. If the patient was unwilling to accept any offer of help, or if none could be offered, he was invited to attend an out-patient clinic held twice weekly by the project psychiatrist and social worker. The location for this clinic was in the Grassmarket Centre, a 'shop front' 'walk-in' type of information and advice centre for residents of the Grassmarket and surrounding area. The clinics for the detoxification patients rarely made appointments for the patients but the men were issued with a card informing them of the times the doctor and social worker would be there so that anyone could come in if they felt like it. The clinics were held one morning and one evening a week. The use made of this facility varied, many men never coming, and some being very frequent attenders. Problems handled were usually of a practical nature but often there was the opportunity to discuss emotional problems. The project social worker devoted much time to some individuals, especially the younger ones, in whom it was hoped to see some lasting change.

Regular meetings of the project team - the full-time workers, supervisors, nursing staff and representatives of

the Grassmarket Project and the Superintendent from the City Police whom the Chief Constable had given special responsibility for liaison with the project, were held monthly in the detoxification ward, the project secretary's office, and Thornybauk Hostel. The difficulties which the project encountered in the RPTC were discussed at these meetings, and are referred to again in Chapter 6.

CHAPTER 6

DIFFICULTIES IN DEALING WITH ALCOHOLIC OFFENDERS

DIFFICULTIES IN DEALING WITH ALCOHOLIC OFFENDERS

SOME SOCIOLOGICAL AND PSYCHOLOGICAL CHARACTERISTICS OF DRUNKEN OFFENDERS

Habitual drunken offenders are not popular people. It is in the nature of their condition, with their characteristics and behaviour, especially when drunk, that they antagonise people and receive antagonism in return. They are usually dirty and dishevelled, unshaven and smelly, sometimes frightening in appearance.

The way in which society reacts to them reinforces their belief that they are unwanted and unliked individuals. Perhaps it is only on Skid Row they are accepted for what they are, and there in fact their deviant behaviour is reinforced and rewarded (Jackson and Connor, 1953). The 'undersocialisation' of such men has been suggested as a cause of their alcoholism and drift to Skid Row (Straus, 1946; Pittman and Gordon, 1958), though Rooney (1961), in a re-evaluation of the undersocialisation hypothesis, showed that far from being a completely disorganised group of misfits, Skid Row contained its own communities with their own particular social structure, having some of the characteristics of the 'normal' society from which they deviated.

In a participant observation study, Rooney observed repeatedly recurring rituals and behaviour of men who made

consistent efforts to be involved in interpersonal relationships which involved emotional reinforcement. The men were seen to belong to groups where they were rewarded with a sense of belonging, security and prestige in which they strove to achieve these ends (the same as in the other social groups from which they deviate) by different means. The Skid Row groups structure social relations around an activity they share, want and need - drinking alcohol. In the group conversation involves retelling past experiences and exploits with the purpose of making one's self or the group feel good ('ego-building mechanisms'). There is usually cursing of police, doctors, social workers, religious missions and other 'do gooders'.

Myerson (1953, 1956) wrote of certain general characteristics of the chronic drunkenness offender; among them a tendency to blame others, bursts of hostility as a reaction to frustration, exaggerated sensitivity to other people's opinion making him appear almost paranoid, and an extremely demanding attitude, without being able to give in return. "By his attitudes the chronic drunkenness offender ends up having alienated everyone."

In a psychiatric study of a large group of habitual drunken offenders, Tyndel (1969) found a third had psychoneurotic disorder and there were personality disturbances associated with this diagnosis. The largest group, 44% were diagnosed as passive aggressive personality

while Kessel and Walton (1965) described the personalities of established alcoholics as being immature, self-indulgent and self-punitive.

Rossenman (1955) has described at length the psychodynamics of the Skid Row alcoholic. He suggests that the motivations of such a man are not dissimilar to those described in some writings dealing with the alcoholic, the masochist and the psychopathic personalities: "the experience of early deprivation; the consequent rage with its accompanying fantasies of and efforts at robbing the significant figures who are comprehended as having despoiled one's integrity, and, more particularly, one's masculinity; the guilt for the rage; the masochistic acting out to expiate and thereby avoid awareness of the guilt; and the paranoid blaming of others for one's miserable plight in order to escape conscious knowledge of one's self-mutilating activities."

Rosenman suggests that the Skid Row alcoholic frequently serves as the 'negative ego image' to the males of our competitive achievement-oriented culture, by virtue of his exemplifying many largely unconscious fantasies of a regressive nature. These include traits of irresponsibility and lack of ambition, self-indulgence, and aggressive defiance of social demands. Rosenman suggests "we may expect that the relatively normal individual who is an unhappy carrier of the negative ego image of a Skid Row alcoholic bum will deal with the Skid Row alcoholic as he would handle that part of himself".

ATTITUDES OF DOCTORS AND NURSES TOWARDS ALCOHOLICS

Alcoholism is not a popular condition for doctors and nurses to treat. Kessel and Walton (1965) write that "alcoholism is an illness; a grudging admission of this is slowly being given by the medical profession".

In the same year that the American Medical Association (1956) decided that "alcoholism must be regarded as within the purview of medical practice", Hayman (1956) found that almost half a sample of American psychiatrists did not treat alcoholics. About half of those who did limited the number that they did treat. The psychiatrists showed no enthusiasm over their therapeutic results and over half had no recoveries whatsoever. The author comments that alcoholics and psychiatrists seem to show a mutual avoidance of each other. "Alcoholism seems to be the delinquent child of psychiatry. It resembles us but we are not quite sure it is our own. We would like to have him, but our house (our facility) is not quite big enough."

Jellinek, in his 'Disease Concept of Alcoholism' (1960), suggested that medical acceptance was essential in order to induce hospitals to accept alcoholics for treatment, as "hospitals in general have developed admission policies that exclude the alcoholic". However alcoholism

continues to be ignored to a large extent, and Robinson and Podnos (1966) estimated that 90% of alcoholic patients receive no treatment. They surveyed 81 consultant and junior psychiatrists and found little more than half accepted alcoholics regularly. The reason for reluctance appeared to be poor prognosis, patients being too demanding and too frustrating, difficulty in coping with patients' acting-out behaviour, and poor motivation.

Intertwined with the characteristics of the patient are the characteristics of the doctor. Mendelson et al (1964) and Gray et al (1969) found that physicians with strong authoritarian attitudes preferred not to, and did not, treat alcoholics. Mogar et al (1969) found that those who did work with alcoholics had a more optimistic and disease-oriented view of alcoholism (as opposed to a 'moral' view - alcoholism is a self-inflicted disease with recovery unlikely and therapeutic approaches unwarranted). Mogar and his colleagues suggest that moralism and pessimism are related to ignorance and a 'casually held stereotyped view' of the alcoholic.

The myth of alcoholism being a disease primarily found in those on Skid Row has largely been dispelled, but not altogether. Wolf et al (1965), in a study of the social and attitudinal factors determining diagnosis of alcoholism in the emergency service of a general hospital, found that diagnostically physicians behaved as though alcoholism was primarily a disease of derelicts, although

in their verbal statements they described alcoholism as a disorder occurring in other social groups. They tended not to recognise alcoholics who were other than derelict, but when they did they hesitated to make the diagnosis. The authors comment that physicians held complex attitudes about alcoholism and towards alcoholics: that these attitudes were intimately intertwined with attitudes about professional goals, values and prestige.

Doctors have certain expectations of how patients should respond to them and vice versa and it is the interplay between the fulfilment and frustration of these expectations that determines behavioural responses in both the alcoholic and the doctor. Abram and McCourt (1964) studied the interaction of physicians with emergency ward alcoholic patients and commented "alcoholism more than many illnesses provokes ambivalent feelings and irrational behaviour among professional workers. These feelings of derision, disgust and anger are those accorded to other mental illnesses a generation ago or tuberculosis and syphilis at the turn of the century."

Abram and McCourt found that the effect of an alcoholic in a busy casualty ward was at times overwhelming. The casualty officer felt that most of the alcoholic's problems were outside the scope of his medical training and he was resentful of having to perform duties and deal with complications for which he had not been trained. He kept the alcoholic waiting an excessive amount of time and

discouraged him from returning. The usual consequence was that the doctor attended to the alcoholic's physical complaints after some delay but ignored his rehabilitation and after-care. Many physicians thought of the alcoholic in strong moral overtones, and often commented "he could stop drinking if he really wanted to", the alcoholic patient seemed to "enjoy" his "illness". In addition the alcoholic frequently violated the doctor's role by diagnosing and prescribing for himself. The doctor's position was also undermined when he realised that the patient had control over the aetiological agent (i.e. willpower). One emergency ward physician commented "I have an answer to the alcohol problem but I have just heard they are trying Eichmann for it".

Similarly Watson (1968) writes of the public drunk as someone who always vexed and angered him. He describes the drunk's "violent or irresponsible behaviour, arising from over-indulgence" being "a nuisance to many, a menace to some, and a burden on hospital casualty services". The author continues: "Why does he get away with it? In a busy casualty department he is a first class nuisance. He interferes with the care of the genuinely sick. He presents a problem which has little to do with the primary objectives of emergency medical care, and which usually makes unrealistic and discordant demands on nursing skills and dedications. Why should young girls be exposed to the degrading language and behaviour of a man suffering from a self-inflicted disease?" The physician suggests

that drunks should not get free medical attention, nor blood from a blood bank. His remedy is "a personal health licence" which can be endorsed "treated for drunkenness", two endorsements resulting in an automatic fine, and three withdrawal of free medical care for a limited period.

Similar attitudes toward alcoholics are found towards self-poisoned patients and Woodside (1958) writes "their admissions may be regarded with disfavour, treatment may be narrowly confined to their physical condition, provision for aftercare or psychiatric investigation haphazard or ignored". Patel (1975) succinctly reviewed the literature on attitudes of physicians and surgeons towards self-poisoned patients and found a common feature of hostility and antagonism shown by all members of staff. In general he found medical and nursing staff considered the patients not personally satisfying to treat or nurse, and they doubted whether the patients benefited from their stay in hospital. The junior medical staff and nursing staff who had more contact with the patients (who tended to arrive late at night or in the early morning and often required gastric lavage when they were drunk and abusive) expressed more unfavourable attitudes toward self-poisoning than consultants.

Barber et al (1975) found that final year medical students and house physicians in Glasgow showed unfavourable attitudes toward self-poisoned patients in comparison with

fourth year medical students and medical social workers. The authors comment that the medical student is at one of the most impressionable stages in his career and developing attitudes toward patients and diseases which can be affected by those that he sees in his teacher. After fourth year students were given the opportunity to have more contact with the self-poisoned patients, they became more interested in their problems and this was supported by a review of their attitudes.

In the same Glasgow hospital Macdonald and Patel (1975) assessed attitudes of consultant and junior psychiatric staff toward alcoholism and found both groups were distinctly unfavourable in comparison with their attitudes towards most other illnesses, particularly organic ones. The authors suggest that more emphasis should be placed on the education of the public, medical undergraduates and "indeed within the profession".

PROBLEMS AND ATTITUDES ENCOUNTERED BY THE PROJECT

a) IN THE ACCIDENT AND EMERGENCY DEPARTMENT

Relations with A & E staff

It is well known that many of the patients who were subjects in this project have been regular visitors to the Accident and Emergency (A & E) Department where they are found to be a nuisance. Sometimes they are allowed to 'sleep it off' in A & E, sometimes the casualty officer

will admit them to the neurosurgical ward for observation overnight (though there is not always evidence of head injury - it is more of a safeguard) and sometimes the men are admitted to the RPTC either because they are severely intoxicated or have (or claim to have) taken a drug overdose. Though figures are not available - because patients can simply be ejected from A & E without being actually registered as having entered and asked for help - it seems that most often patients do not have anything done for them, and if they are seen before being discharged, it is because the casualty officer has a concern that there may be something other than drunkenness wrong with the man.

It was therefore thought initially that the project would not be unwelcome to the A & E staff, as all that was now required was a brief physical examination (to exclude physical illness which would require admission elsewhere) followed by a call to RPTC for the patient to be admitted directly. It was also considered that the patients might 'behave better' in A & E as there would be less reason for aggression if they were getting what they wanted - i.e. admission.

Unfortunately it became clear early on in the study that the consultant in charge of A & E had little enthusiasm for the aims of the project. He co-operated to a great extent but already had firm views regarding the patients. In the author's hearing, he told his junior staff that they were in his opinion 'not really patients' and expressed in

strong terms his view that they misused the NHS. Similar attitudes seemed to be quickly adopted by the casualty officers, who changed every six months and usually had no previous experience or teaching in how to handle such patients.

The project psychiatrist tried to enlist optimal co-operation by regular discussions with receptionists and nursing staff in A & E and regular meetings with new doctors joining the staff there. Written instructions concerning the project, how it affected A & E staff and a specimen 'yellow card' were given to the staff. They were understandably annoyed on the very few occasions (three in the course of 14 months) when the admission procedure broke down at the RPTC end. On other occasions worries were expressed concerning imagined 'abuses' - such as men arriving saying that they had lost their card, cards being stolen, cards being handed to non-listed men, or even sold for a bottle of wine. Not one such 'abuse' was in fact ever confirmed.

Difficulties did arise when patients arrived from A & E on the RPTC ward without the copy of the casualty officer's notes of his physical examination, and sometimes these notes only said 'Detox. patient - admit RPTC' or the like, giving no indication of whether the physical examination had been done. The RPTC nursing staff complained about this as they did not know whether to call another doctor to examine the patient. These misunderstandings

were usually clarified by communication with the casualty officers, facilitated by the project psychiatrist.

Patients were not as quickly transferred from A & E to the RPTC as had been hoped, often remaining there for some period of time, understandably being low in priority for attention on a busy night. In several instances the patients were abusive to the staff, who were not always able to handle this in an objective and good humoured way. There were also occasions when men did behave violently - not physically assaulting the staff (though one senior nurse did say she had been grabbed and her arm twisted) but (on two occasions) breaking furniture or windows. With our full approval at these times the police were called to remove the patient who was usually then charged with 'Breach of the Peace'.

Views of A & E staff on the project

When the project was transferred from the RPTC in April 1974, the written views of the medical staff in A & E were sought and 11 out of 12 doctors who had been involved replied. A selection chosen to convey the overall impression is recorded.

Casualty Officer A

"The project patients could be divided into three groups: firstly, those brought in by the police drunk, no injuries. These patients were easy to deal with, requiring only a short examination to ensure they would survive the night before

being admitted to the RPTC. A few were uncooperative but there was always plenty help available to subdue them.

Secondly, there were those brought in by the police drunk, with injuries. The injuries were never serious and such that they would have been brought whether or not project patients. Disposal was always easy as the decision whether to have the patient in a police cell or head injury ward was not necessary and the casualty officer had peace of mind knowing the patient would be in the care of nurses all night.

The third group comprised 'Patient AB and other charmers'. They arrived self-referred not drunk enough to be arrested, usually motivated by the desire of a free bed and breakfast . . . often confirmed by hearing they signed themselves out next morning. They were just nuisances.

In conclusion, the project was useful to me as a casualty officer. The extra work by patients in the first group was offset by a guaranteed bed for those in the second group. Those in the third group would probably have been nuisances even if they were not in the project."

Casualty Officer B

"The project was established, as I recollect, to provide alternative overnight accommodation to the cells, for those chronic 'drunk and incapables' upon whom the prospect of police custody had clearly had no deterrent effect whatsoever.

Attractive in its conception, the scheme nevertheless, seemed to have little significant effect on

the drinking habits of its clientele. Probably the main reason for this was that alcoholism is very difficult to treat effectively in any subjects, but almost impossible with the circumstances and lack of motivation of the 'yellow card' carriers.

As far as my own experiences are concerned, I found a steady dribble of these people presenting themselves at the department, particularly when on night duty. Frequently they walked in, perhaps a little unsteadily, but quite capably, and demanded a bed in the RPTC for the night. Initially I stood on ceremony, told them they were not genuinely 'D & I' and could get out the way they came. For them, of course, the logical thing in that situation was to drink more, become sufficiently incapable to require police escort back to the department, then get the bed they'd come for in the first place. Later on, therefore, I admitted all but a very few on their first visit, after appropriate history and examination. RPTC being preferable in many respects to the doss-houses, our friends inevitably manipulated the scheme, the suspicion being that they might well be drinking more than they would otherwise have been doing, in order to get clean sheets for the night.

My general impression, therefore, is that, though the scheme was worth trying, it had little chance of significant success."

Casualty Officer C

"Any effort at removing the inebriate population from the casualty department is welcome. The burden on the casualty officer was however in no way lightened as he still had his duty to the patient with respect to other medical problems, in association with the

poisoning aspect. I felt that the only benefit derived was the dubious one of the alcohol laden being able to 'cock a snoop' at the constabulary in situations where they would otherwise be incarcerated. I doubt if any cures accrued."

Casualty Officer D

"There was certainly some suspicion that these cards were being used by the bearers as an excuse to get a bed for the night in the Infirmary, although this was an impression I could not substantiate."

Casualty Officer E

"I feel the responsibility for admission to the RPTC for these patients should have fallen on the shoulders of the psychiatrists running the project, rather than the A & E staff. I personally had no objections to referring anyone on the 'yellow card list' to the RPTC if in my opinion he was literally drunk and incapable. Too often these 'patients' either presented themselves or were escorted in police custody to the Department claiming their 'right' of admission, when in fact they were neither drunk nor incapable. When denied their 'rights' they were often abusive and occasionally violent, taking up valuable medical and nursing time."

Comments

The comments of casualty officer A seems a balanced view. He notes that the patients would have been nuisances whether or not in the project. What seems to

annoy doctors is that the alcoholic is getting a 'free bed' - implying that he is not entitled to this, that he is obtaining something he has not 'earned' by having symptoms of a universally accepted medical illness. Alcoholism seems to be construed as 'badness' on the patient's part, in other words something over which he has control. Staff quickly forget that it is in the nature of alcoholism that the patient has lost control over his drinking.

Casualty officer B has a good idea of the aims of the project though not of the intended methods of handling the patients following admission. His view, and those of others, that no effect was made on the subjects' drinking habits is no doubt a correct overall impression to them, but influenced by their only seeing the patients who did return repeatedly, whilst forgetting those that did not come back.

Comment is also made here on the patients not being incapably drunk and perhaps going out to drink more in order to secure admission. My own questioning of the casualty staff on who were these patients always resulted in only one name being offered - patient AB referred to above.

The opinion of casualty officer C vis-a-vis the 'constabulary' is not borne out by the police themselves (see later). The writer seems to consider the project set out to 'cure' deteriorated alcoholics.

Interestingly casualty officer D cannot substantiate the 'free bed' impression. It should be noted that patient AB, generally considered the worst 'offender' at this, had, in fact, usually paid for his bed a week in advance at the nearby common lodging house.

The comments of casualty officer E are a curious mixture - the writer thinks he should have had nothing to do with the men, but he did not mind referring them. Again it seems the patients' assertions of their 'rights' seems to be what causes annoyance. His 'valuable time' is being taken up by men he does not really consider as 'patients'.

On discussion with the casualty officers they admit it is extremely difficult, if not impossible, to know how intoxicated - meaning how high is his blood alcohol level - a man is, and they may often be 'drunk' but 'not incapable'. The feeling however seems to be that the man should be 'horizontal' rather than 'vertical' to warrant admission. More information on this subject would have been available had blood samples been taken on admission for estimation of blood alcohol. Unfortunately the previously agreed procedure, that certain senior nurses with permission to perform venepuncture should do this, was rarely followed.

The clinical notes completed by the A & E doctors after seeing a 'detox.' patient were usually brief and occasionally contained hostile and sarcastic remarks. One is particularly worthy of note (on patient AB). "Talks incoherently but manages to pronounce the word 'detoxification' all right."

b) IN THE REGIONAL POISONING TREATMENT CENTRE

At the termination of the project in the RPTC nursing staff there were asked for their comments on the project and these are given here together with comments noted and documented from the medical and nursing staff throughout the year the project ran in the RPTC.

Expectations of nursing staff

One problem seems to have its origin at a time prior to the full-time project research workers being appointed. At that time, when proposals for the project were being circulated, the nursing administration consider that they requested extra nursing cover for the RPTC particularly in the evenings and week-ends. Another view is that an offer of male nurses was made but rejected by the ward Sister.

Although the consultant in charge of the RPTC was one of the three consultants awarded the research grant, nursing staff felt they had not been adequately told of the implications of the project and often voiced their feelings that the project had been 'dumped' on them, that they had never chosen to work with that group of patients but were primarily interested in the intensive care of poisoned patients. Discussion had in fact taken place prior to commencement of the project between the ward nursing staff, physicians and psychiatrists, and the admission policy and treatment procedure agreed. However when patients began to be admitted, nurses found the

patients "required unpleasant care in the cleansing of incontinence and vomitus, created disturbance by noise and abuse, required delousing, produced excessive use and wastage of bed linen particularly when readmitted soon after discharge, caused distress to other patients by their attitudes and responses and caused nursing time to be diverted from acutely ill patients".

The comments regarding incontinence, vomitus, delousing, bed linen and nursing time are accurate though their frequency of occurrence was unfortunately not recorded. However they might reasonably be expected from the type of patient being admitted. We are not able to substantiate or deny comments on distress to other patients, but suggest that if this was so, it could have resulted in part from the method of handling the patients on admission. This suggestion is made on the basis of our experience after transfer of the project to the psychiatric hospital.

The RPTC usually had a male porter on duty by day, and at all hours a bell in the ward could be rung to summon assistance from porters. We experienced difficulty with one porter who was well acquainted in many ways with our 'Grassmarket' patients; arguments and ill feeling could be created because of patients' difficulty in accepting his authoritative role in the ward. We found it impossible to discuss with the porter his reactions to and handling of the patients because of his prominent defences which

manifested themselves in his threat to refer any criticism of himself to his Trade Union.

Relationship between Project Team and RPTC staff

The project psychiatrist was often 'blamed' for 'poor communication' between the project team and the nursing staff. The extreme view, of a senior member of the nursing administration, was that the psychiatrist "had nothing to do with the patients on admission, saw them only briefly in the morning, took no interest in the problems of their admission to the ward, expected no information or comments from the nursing staff and supplied no professionally interesting data about the patients and the project to the nurses".

The previously agreed procedure was not that the project psychiatrist would see the patients on admission as it would not have been possible for him to do so unless he was 'on call' continuously. The patients were seen briefly in the morning, the reason being that the consultant in charge of the ward required details of the patients on his 8.30 a.m. ward round. The project psychiatrist agreed to arrive at the ward each morning before 8 a.m. to see the patients in order to have something to comment during the round. At the request of the project team the consultant in charge agreed to change his routine and to start his ward round in the female rather than the male ward; this change of routine lasted only two weeks.

After the ward round the project psychiatrist did see the patients again and then discussed their management with the project social worker. On several occasions the project psychiatrist asked the ward Sister for time to be set aside each morning to discuss the patients with the nurses as would be the practice in psychiatric wards. The ward Sister always put this off, replying that there was no convenient time. The project psychiatrist and social worker offered to sit in during the Sister's early morning nursing report to her staff: this time was said not to be suitable. The project team as a result felt that the ward Sister did not wish to discuss the patients. It was possible however to have some valuable discussions with the nursing staff more informally and irregularly, such as over coffee.

Factors causing difficulties

Communication between the project team and the nursing staff was not helped by the team having no rooms of their own in the RPTC, their office being located in the psychiatric hospital three miles away. On more than one occasion the ward Sister was heard to say that she wondered what the project psychiatrist did all day. Because he was not seen to be working throughout the day and because he acted as an 'advocate' for the patients, it appeared that the project psychiatrist was often identified with them, apparently being thought uncaring and lazy.

Strong feelings were expressed about the amount of time spent by each of the project team and the physicians on the duty rota, that for instance the project psychiatrist was 'on call' less often than others. Again this had no foundation whatsoever in fact, but the consultant in charge of the RPTC insisted that the project psychiatrist be 'on call' on alternate nights, and this was agreed.

Another important factor seemed to be that the nursing staff only regularly saw the 'repeaters', those few patients who were repeatedly readmitted, apparently forgetting those only admitted once or twice. This resulted in an impression that all the patients were doing likewise, and the project team were probably at fault in not spending enough time giving feedback information on the others. An attempt was made to rectify the situation by issuing an open invitation to all medical and nursing staff to visit the psychiatric hospital but this offer was never taken up. The team did however manage to hold their regular monthly meetings in places other than the RPTC - in the psychiatric hospital and in Thornybauk Hostel.

Most of the patients who did successfully start the process of rehabilitation were residents of Thornybauk Hostel, but it did not open until nine months after the project started in the RPTC; the RPTC staff thus had little opportunity to hear of 'successes'.

One of the consultant psychiatrists of the project team offered to have informal meetings with the nurses but these were poorly attended and not a success - the nurses giving the reason that they expected to be taught by lecture at these meetings, whilst the consultant psychiatrist saw the purpose to allow the nurses to air their views about the project and discuss possible solutions.

Further attempts to resolve difficulties

In order to cope with the difficulties being caused by admission of project patients, attempts were made to alter the admission procedure. Some patients who were being repeatedly readmitted and seemed not to be benefiting, were informed that this could not continue and were told that they would not be readmitted within a week of their last discharge. The recruitment of further patients to the enrolment list was halted when the nursing staff complained that they had too many men to cope with. The admission rate in the RPTC was about 3-4 admissions per week with about three patients in the ward at any one time (a maximum of six being reached once), not a high proportion of the total number of admissions of self-poisoned patients - about 30 to 40% of admissions. Furthermore it was agreed that if too many patients presented for admission, some of those already there could be transferred directly to wards in the psychiatric hospital.

It was decided nevertheless to curtail the duration of stay of each man unless the RPTC medical staff could be convinced that the patient genuinely needed a week's detoxification. Unfortunately this resulted in the RPTC being used more as a 'sobering-up station' than a 'detoxification and assessment centre', although the patients themselves played their part in this situation being reached by often insisting on taking their own discharge.

To help cope with patients on admission the project team suggested that an approach by Alcoholics Anonymous members in the city be taken up with a view to their assisting with the management of the acutely intoxicated men. Objections were raised that this would cause 'medico-legal' problems and the matter could not be pursued.

Termination of project in RPTC

Despite these attempts to facilitate the running of the project in the RPTC, matters continued to deteriorate with increasing rejecting and hostile attitudes being developed and expressed towards the project team and their patients.

One patient brought to the RPTC by the police was discharged by the staff as they considered him insufficiently intoxicated: the police found him, thought he still needed

to be taken into custody for his safety, and were understandably concerned at the rejection of the patient by the ward. On another occasion the RPTC staff on being informed by A & E that they had a patient ready for admission refused to see the patient or admit him. Another police-initiated referral was refused, with the result that the patient was again kept in a police cell overnight. On at least one occasion a patient was known to have asked the police not to take him to the RPTC, preferring to be detained by them and charged.

A further incident occurred when the project social worker arranged to take a patient with locomotor disability in her car from the RPTC to be admitted to Thornybauk Hostel. Before she arrived at the ward the patient was discharged without a previously requested stick which he required for walking and not knowing where to go. On several occasions patients were discharged from the ward by the medical staff without consulting or informing the project psychiatrist. Sedation prescribed for the patients was not given or only administered after considerable delay. More than once the project psychiatrist, and even his wife, received abusive and aggressive phone calls from one member of the medical staff on purely administrative matters at inconsiderate hours.

Transfer of project to psychiatric hospital

Undoubtedly the main reasons leading to the failure of the management of the project in the RPTC can be attributed to the characteristics and behaviour of the patients. They were not pleasant patients for nurses to treat on admission, some being dirty, noisy and abusive. They were not easy patients for the project psychiatrist and social worker to treat and the lack of rehabilitative resources in the city meant that patients could not always be offered any further help even if they wanted it. It would have been an advantage for the project team to have been based in the RPTC and to have been a larger team so that at least one member could be present in the ward at all times to encourage and assist the nurses.

The hostile attitudes of the A & E staff towards these particular patients preceded the project, and their workload could hardly have been increased by it. Many of their comments about the failure to 'cure' the alcoholics have their basis in lack of sensitivity to the problem of alcoholism being a chronic disorder characterised by relapses and remissions. It is difficult for them to accept that readmissions are something other than 'failures'. Indeed such readmissions were integral to the aims of the project. Doctors and nurses in medical and surgical wards understandably like to 'treat' patients and see an end result of a 'cure' and this was not part of the aims of the project. Psychiatrically trained nurses and doctors

are more accustomed to recurrences of chronic illnesses. They are trained to be more objective in their handling of disturbed patients and of their feelings about being 'unsuccessful' therapists.

After 14 months in the RPTC the nursing staff were dissatisfied with the project to such an extent that they requested additional nursing staff. However it was clear that had such provision been possible it would not have solved the difficulties. Accordingly on 1st April 1974 the project was transferred to a general psychiatric ward in the Andrew Duncan Clinic in the Royal Edinburgh Hospital. The consultant in charge of the ward was also one of those awarded the project research grant.

This section has dealt almost entirely with negative feelings expressed by the RPTC and A & E staff as these were the reasons for breakdown. However there were positive aspects too, and these are referred to in d) below.

c) IN THE PSYCHIATRIC HOSPITAL

The transfer of the project to the Andrew Duncan Clinic (ADC) was carried out without undue difficulty, the police knowing well in advance and all notices and documents having been appropriately altered. Most of those patients who had not learned of the transfer soon found out and the 'yellow cards' were also altered. One charge nurse from the ADC who was to be intimately concerned with the project

in the ADC spent a fortnight visiting the RPTC regularly prior to the transfer in order to note their method of management, learn of their difficulties, and to get to know some of the patients.

Difficulties in the Andrew Duncan Clinic

In general the patients presented the same problems in the ADC as they did in the RPTC. They continued to discharge themselves against medical advice, often turning up for admission one or two days later. Sanctions (no admission for one week after discharge) were again used on occasions to protect the morale of the staff and although patient AB had completed his eligibility for admission whilst the project was in the RPTC, the ADC had a worse 'repeater', patient CD. However these same problems created virtually no stress, and certainly no acrimony presumably because of better communication and understanding between project team and nursing and medical staff.

In the ADC there was no A & E Department for the patients to pass through but incidents of bawling and shouting did occur in the out-patient reception area. On one occasion there was fisticuffs in the ward between three patients and one patient was only just prevented from throwing a chair across the room. Because of the particular patients admitted most often to the ADC (and their visitors) and as the length of stay was relatively longer, patients were more likely to be suspected of

drinking in the ward. To our knowledge this almost certainly happened on three occasions.

Views of ADC staff

Opinions on the project were collated from the nursing staff by two senior nursing officers and these are their views:

Psychiatric Nursing Officer A

"There was no obvious sign of the patients' presence in the ward. During my visits it appeared, and functioned, like the other admission wards of the unit. Occasionally, one of the men would be noisy and unco-operative - especially one fairly regular attender - but not to an extent never found amongst the general run of admissions.

Although the men were 'isolated', so far as was possible, from the general admission ward patients some contact was inevitable and to the best of my knowledge there were no complaints about their presence in the ward. Certainly, none was ever brought to my attention. I should think it possible that a number of the patients were unaware that there was a 'special' group in the ward.

Staffing of the ward was specially arranged and finding suitable replacements for the permanent staff - e.g. at holiday times - did not constitute a major problem, nor were the other wards deprived of an adequate number of staff. It did, however, mean that nurses were called upon to work overtime more often than would normally have been the case. Possibly the greatest staff difficulty was, on occasion, having to

quickly find enough staff to help escort an obstreperous man to the ward. The staff who were permanently involved in the project seemed to be interested in it and to like the work involved. I was very seldom called upon to give a second opinion of any sort. The staff appeared to be well versed in what to do in any particular difficulties."

Psychiatric Nursing Officer B

"The project seemed to operate smoothly without being a cause of great concern to the staff involved or disrupting unduly the routine of an admission ward at night. I cannot recall an occasion when members of staff expressed feelings even mildly antagonistic to the project and think this might be due in some measure to the preparatory work done before its transfer to the Royal Edinburgh. One charge nurse in particular appeared to take a keen interest in the research and to derive stimulation from his involvement. Although at times female night staff were associated with the project in the ward, it may be that a predominantly female group of staff would have found the situation more stressful than their male counterparts - largely because of anticipated potential violence which in the event turned out to be more imaginary than real. The geographical layout of the ward did allow some segregation of the noisier admissions at night and minimised disturbance to other patients, but better facilities, e.g. disinfestation, would have been an advantage."

The medical staff most intimately concerned gave their views:

Psychiatric Registrar

"I was glad to be associated with the project though at times I felt pretty annoyed when men were being readmitted on the day of discharge, repetitively. I recall that we adjusted the rules so that only 'x' days per fortnight were spent in hospital. It was inevitable that the men would regard the system as something 'to use' to some extent, and that the reciprocal feeling of 'being used' (taken for a ride?) would be engendered in many of the staff. One lived with this feeling and for the most part it did not seem to rankle.

That is, as long as there seemed to be some point to the project. (To me, though I was interested to know the outcome in terms of rehabilitation, the main point was restoration of dignity.)

The only positive aspect of its being in a general ward was the relative ease with which nursing staff of high quality and skill could be arranged for the project. I am sure being seen as a patient helped the men's self esteem, though I felt that in the ward where the project was located there were two classes of patients, and that the 'detox.' men were second class citizens. I suspect that this may have increased their bitterness and alienation rather than diminished it.

I do not really think the presence of the project significantly affected the well-being of the other patients in the ward. Of course we were using the explanation that the project was 'an experiment' and this explanation was given to the non-project alcoholics who had been told that drinking from the ward meant discharge and who after treatment had finished were sometimes not readmitted if they had returned to drinking soon after."

Senior Registrar

"The positive aspects seem obvious to me. Patients were going through a period of care, with medical attention not only for emergencies, and with withdrawal symptoms treated by experts in the field. Comparison with the same period spent in the police cell leads to evident conclusions. Some patients had more chronic ailments investigated or treated, a situation which probably is unlikely to occur with surgery attendance or out-patient appointments because of their erratic life-style. Patients had the opportunity of being talked into admitting to problems with drink, to attend Alcoholics Anonymous meetings in the ward; these again were situations unlikely to occur to a satisfactory degree in their outside life. Some of the other patients considered the detoxification patients as likeable companions and a few friendships were formed; some of them were more integrated into the ward community than others.

One of the most disturbing factors was the tendency, a short time after the project had been functioning in the hospital, for patients to insist on taking their own discharge, returning intoxicated a few hours later. Many of the staff and even some (non-alcoholic) patients felt they were misusing the treatment facilities or mistaking them for a hotel. This, coupled to the distress caused to others by intoxicated arrivals, probably were the main factors leading to occasional dissatisfaction amongst staff and patients. Other episodes of temporary attention were due more to slight administrative slip-ups, and told us more about the difficulties in getting a project like this working than anything else. Of course we had to deal with the fact that some patients came in with their hidden alcoholic reserves, apart from receiving visits from well intending friends (with bottles).

In summary, the project on a general psychiatric ward had many positive but also negative points, but on balance it worked out very well as far as staff and other patients were concerned."

Comments

These more objective comments from the ADC staff demonstrate the same feelings of annoyance and frustration at readmissions soon after discharge but are couched in less emotive terms. Some points are raised on the difficulties of locating the project in a ward where other psychiatric patients may include other alcoholics being treated by a different policy. No project patients were refused admission in the normal run of events, always being given the benefit of the doubt to make life easier for all concerned.

It is clear from the comments of nursing officer B that the preparatory work prior to the transfer of the project from the RPTC was well worth while, all staff in the ADC knowing more or less what to expect. It is also evident in retrospect that there was insufficient preparatory work prior to commencement of the project in the RPTC.

d) THE PATIENTS

Two patients who agreed to participate in the project became so unco-operative that it was decided to remove them

from the proband group (23 and 315 days after enrolment). Both had created considerable disturbance in A & E and the RPTC and were impulsive and aggressive characters whose personality disorder was probably more prominent than their alcoholism. Both were well known to the local police for their anti-social behaviour. They were 'delisted' at the request of the RPTC nurses and without much dissension from the project team.

Section b) above contains references to the negative feelings expressed by the nursing staff in the RPTC towards the patients but it would be misleading to think that it was normal for the patients to be in any way badly treated. We found the nurses to be warm and friendly and highly skilled in nursing the men.

The nursing and medical staff were not inflexible in their attitudes towards admissions. One patient (EF) at the time of his enrolment was cohabiting with a female alcoholic. The couple always became intoxicated together and it was decided by the project team the most appropriate action was to admit them together to the RPTC, though Mrs. EF was not of course officially a patient. The referrals of these two were never through the police and often initiated by the project psychiatrist and social worker who often saw the couple in their home for follow-up. The ward staff reluctantly accepted the necessity for their simultaneous admission, but were often warm and considerate to Mrs. EF.

We also noted that although patient AB was generally unpopular for his repeated admissions and in general the nurses were glad to see his discharge, on one occasion the project psychiatrist was asked not to discharge AB until the following day, that being AB's birthday and the nurses had made him a cake.

Some more sentiments are expressed in a lyric composed by three RPTC nurses:

"(Sung to tune - La Traviata)

Jackie you're drunk to-day
drunker than yesterday
Now you've come back in here
but there's no bed we fear.
You think that we're all thick
But we're just bloody sick.
Each day the same old face
It is a damned disgrace.
You shake your yellow card
and think you can't be barred
Well here's the final shock
No nurses, just a detox. doc.

Chorus: detox. doc.
detox. doc.
one de-tox. doc."

e) VIEWS OF THE POLICE ON THE PROJECT

At the time of transfer of the project from the RPTC to the ADC the Chief Constable, at our request, obtained the views of the police from the different Divisions in the city:

Chief Superintendent A

"The arrangements whereby offenders were taken to the detoxification centre caused no great inconvenience to the police, and the general feeling is that the project is worth-while as it presents a more enlightened approach to the problem of the persistent drunken offender.

Views have been expressed however that the aim of trying to rehabilitate the chronic offender is perhaps too ambitious in that it may be wiser and more productive to concentrate on a more responsive element. Valuable experience should thereby be gained before tackling the chronic habitual drunkard.

The problem of the drunken offender has been with us for many years and the intervention of other social agencies who are keen to help is most welcome. The aims of the schemes are most progressive and while they deserve to succeed, those in charge of the project are best equipped to comment on its effectiveness."

Chief Superintendent B

"Normally no difficulties have been experienced in identifying and conveying drunken offenders to the detoxification unit. However, offenders are admitted to the unit via the Accident and Emergency Department

and difficulties have arisen in this respect. It is apparent that the medical staff there regard offenders as a nuisance and their subsequent examination by the casualty officer takes very low priority when surgical patients are waiting for treatment. As a result, since offenders are technically under arrest, police officers accompanying them must remain at the hospital and may in fact be detained for considerable periods.

Occasionally offenders still under the influence of alcohol discharge themselves from the unit and again merit police attention on the street.

My opinion is that while the objects of the project are laudable, consideration must be given to the admission procedure, and also the secure detention of offenders to prevent unnecessary wastage of police time and resources."

Chief Superintendent C

"All station sergeants consider the project a success and feel that the scheme offers some hope for the habitual drunkard. All agree that the cycle of arrest, court, prison, etc. serves no useful purpose and has no curative effect.

Since the inception of the project no major difficulties have been encountered. On two occasions however the recommended procedure was not carried out. On one occasion a man was detained at a distant police station and because of transport facilities his transfer to the detoxification unit was delayed. Upon arrival at the hospital the staff there considered the prisoner was not sufficiently drunk to be admitted. The prisoner was thereafter taken to the police headquarters and treated as a routine 'drunk and incapable'.

On another occasion a man was taken to the hospital where he became unco-operative and objectionable and was eventually charged with committing a breach of the peace within the hospital precincts.

Apart from these minor incidents, the scheme appears to be a success and a worth-while project."

Chief Inspector D

"While the detoxification scheme is also a saving of time by charge office staff in so far as the documentation and detention of the individuals is concerned, beat officers responsible for taking a participant to the detoxification unit are often detained for a longer period there than they were formerly at the charge office.

On balance, any system which relieves the courts of the problem of knowing what to do with alcoholics, and the police from having to take them into custody and restrain them until they are sober, is a good one. The police should continue to concern themselves with the detoxification project so long as the medical authorities are in a position to accept these unfortunate persons."

Comments on police views

Certainly one of the most irritating problems so far as the police were concerned was the handing over of the patients at the Accident and Emergency Department and when the project was transferred to the psychiatric hospital no such difficulties were encountered. In fact, from then on there were no further complaints of patients being

discharged while still drunk, or of any other nature. The police have often commented on the 'unsuitability' of trying out the detoxification scheme on habitual offenders, suggesting that 'first timers' or younger patients should be tried first.

The Divisions of the police were again asked for their comments after the project had terminated in the psychiatric hospital and all reported no problems or difficulties in that period:

Chief Superintendent E

> "All offenders conveyed there by the police were admitted immediately without question and the man hours involved by the officers concerned was minimal."

Chief Superintendent A

> "In general the feeling of the station staffs is that their workload and responsibilities were lightened by the removal of drunk prisoners from police custody. It is also the general opinion that treatment is more important than detention for these cases."

SUMMARY

Undoubtedly some of the difficulties encountered by the project in the RPTC could be attributed to the personalities of the individuals concerned, both among the staff there and in the project team. Two of the grant holders were about to undergo major changes in their lives, one approaching retiral, the other promotion. However it is likely that similar difficulties may arise in other detoxification projects.

Alcoholics are not popular patients, being unrewarding in terms of 'success' unless those involved have a good understanding of the relapsing nature of the condition. Drunkenness is often seen as more immoral than medical and it is not surprising that nurses have conflicting feelings when handling dirty, abusive and unco-operative men. If they have not volunteered to perform these tasks, resentment easily builds up.

It is clear that if detoxification is to become a routine part of the work of doctors and nurses, full discussions of the implications must be carried out with all concerned beforehand. If possible help should be sought to assist nurses with admissions, by Alcoholics Anonymous or other volunteers.

Careful consideration must be given to those patients who cause the greatest trouble. It may be as well not to try to cater for those who are habitually physically aggressive and to leave the police to deal with them. Those patients who repeatedly discharge themselves and seek readmission are a major problem. For some men many admissions are necessary in order for them to know and trust the staff and accept onward referral. However for some this point did not come in our study and some may actually drink more and deteriorate more rapidly with short spells of admission for detoxification rather than longer spells in prison. Imposing 'sanctions' (e.g. no admissions for a week following discharge) in some way defeat the

objects of the exercise, but we found it necessary in order to protect the morale of the staff.

Patients who do well after referral should be encouraged to return to the detoxification unit to show themselves to the staff. Those administering the detoxification unit must be aware of the importance of feedback to their staff, and to the police.

CHAPTER 7

ADMISSIONS FOR DETOXIFICATION

ADMISSIONS FOR DETOXIFICATION

DESCRIPTION OF WARDS

The detoxification facility was located in the RPTC from February 1973 until March 1974 and in the ADC from April 1974 until February 1975. The male ward in the RPTC has 12 beds in a traditional 'dormitory' ward with a locked door. A fixed number of beds was not set aside for the project patients but it was considered that as recruitment of the cohort took place over the course of a year no more than six beds were likely to be in use at any one time. As stated in Chapter 6, this maximum was reached once (on which occasion a control patient had succeeded in being admitted by flashing a yellow 'diabetic' card to the A & E staff). The usual number of beds used per day was about three.

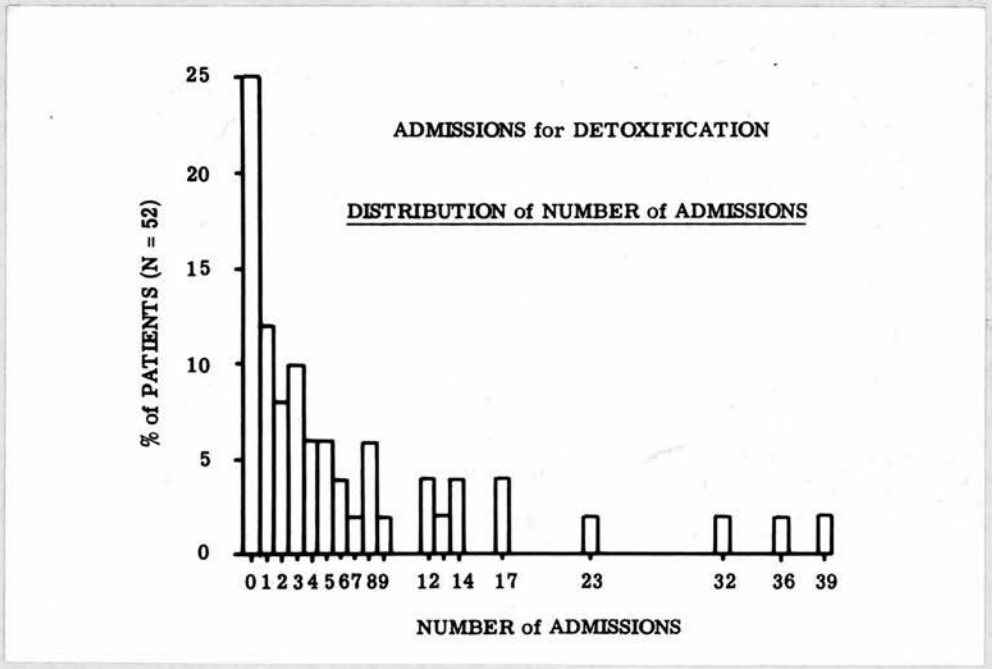
In the ADC, the detoxification centre comprised four beds in a 12-bedded male section of the ward partitioned into three sections. The detoxification beds could be overlooked by a window from the nurses' duty room. The door to the ward was only locked at night.

NUMBER OF ADMISSIONS

There were 195 admissions to the RPTC and 142 to the ADC, 337 in all. In the 52 probands available for

admission, 39 were admitted at least once, 13 not at all. The number of admissions per patient ranged from one to 39 and the distribution of number of admissions per patient is shown in Fig. 2:

Fig. 2



It is seen that three patients accounted for 32, 36 and 39 admissions each or 32% of all admissions. The patients with 32 and 36 admissions had the majority of these to the RPTC, those with 17, 23 and 39 admissions had most of theirs to the ADC, thus the 'gross repeaters' were known to the staff in both centres.

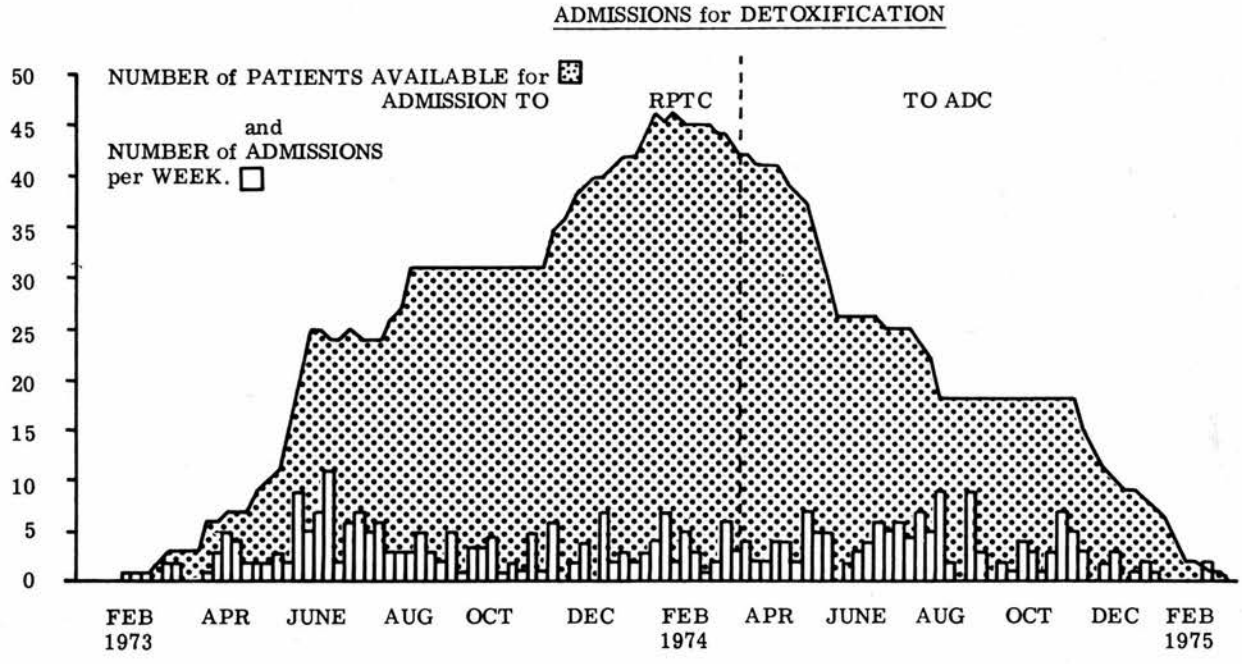
The mean number of admissions for all men available for admission was 6.5 admissions and for those admitted at least once 8.6 admissions. Adjusting for those not completing a full year's eligibility (e.g. because of death) the mean for all men available was 6.9 admissions and for all those admitted at least once 9.2 admissions. However these averages conceal too high a degree of skew, as seen from Fig. 2, to be meaningful.

RATES OF ADMISSION

Some patients had their whole year's eligibility for admission to the RPTC and some had the majority of their time while the facility was located in the ADC.

Each week during which the project was operating there were a different number of patients available for admission as enrolments continued through the course of a year adding to the number, whilst others died or completed their year's eligibility for admission. Fig. 3 shows the number of admissions per week compared with the number of patients available for admission:

Fig. 3


ADMISSIONS for DETOXIFICATION
NUMBER of PATIENTS AVAILABLE for ADMISSION TO RPTC
and
NUMBER of ADMISSIONS per WEEK.
TO ADC
50
45
40
35
30
25
20
15
10
5
0
FEB 1973
APR
JUNE
AUG
OCT
DEC
FEB 1974
APR
JUNE
AUG
OCT
DEC
FEB 1975

It is seen that from the onset of the project the number of admissions rose steadily with an increased number of patients available for admission for the first five months but after June 1973 there was no such association. Whilst there are other factors that might explain this, it does not appear to be a chance coincidence that it was in July 1973 that the greatest difficulties were encountered in running the project in the RPTC. The relationship between the project staff and the ward staff at that time had reached a low and distressing point and it seems reasonable to conclude that this had some bearing on the admission rate.

The rate of admission can be calculated from the ratio of number of admissions per month to the number of patients enrolled on the mid-point of the month. For the RPTC the ratio has the range 0.27 to 3.0, standard deviation 0.88; for the ADC the range is 0.35 to 4.0, standard deviation 0.96. There is no statistically significant difference in the admission rate between the two centres.

There is no peak of admissions during the winter months as might have been anticipated for individuals, many of whom were homeless, the trend being more towards a higher rate during the summer.

TIME OF ADMISSIONS

As can be seen from Fig. 4, admissions were equally distributed between days of the week with Sunday under-represented:

Fig. 4

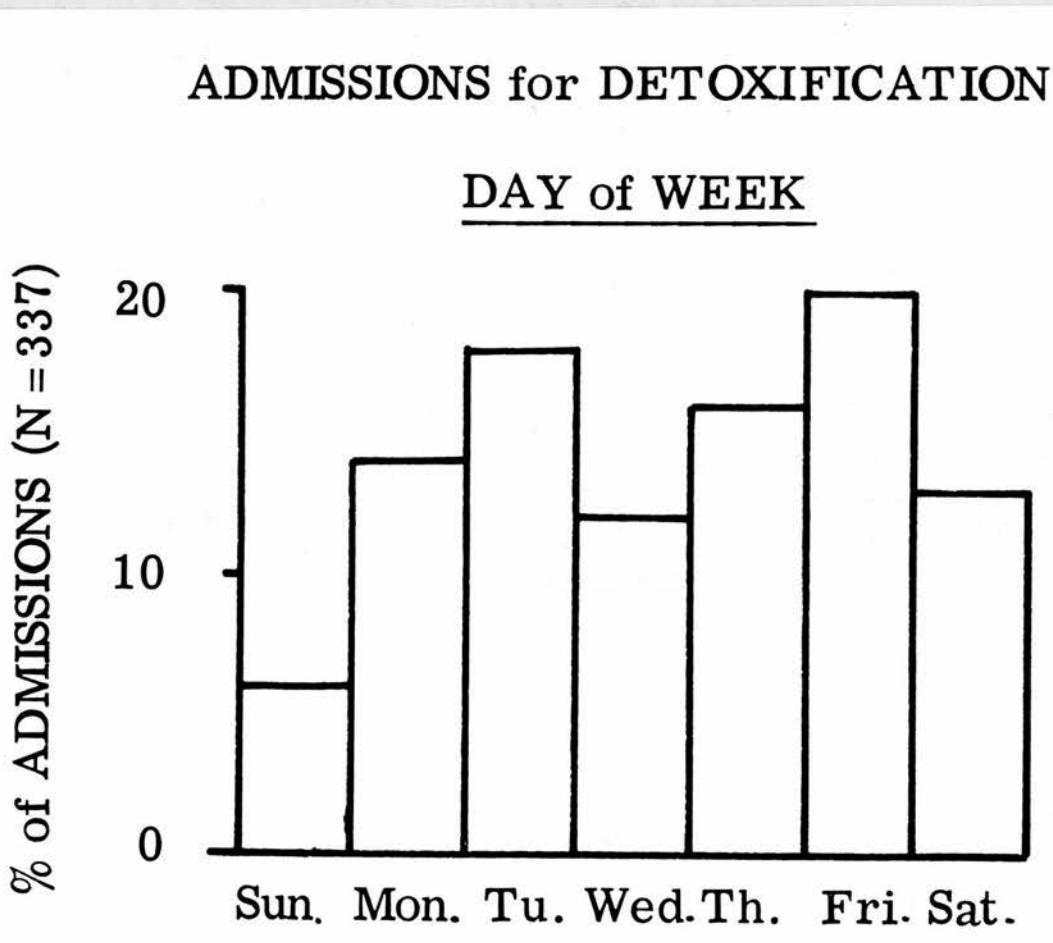
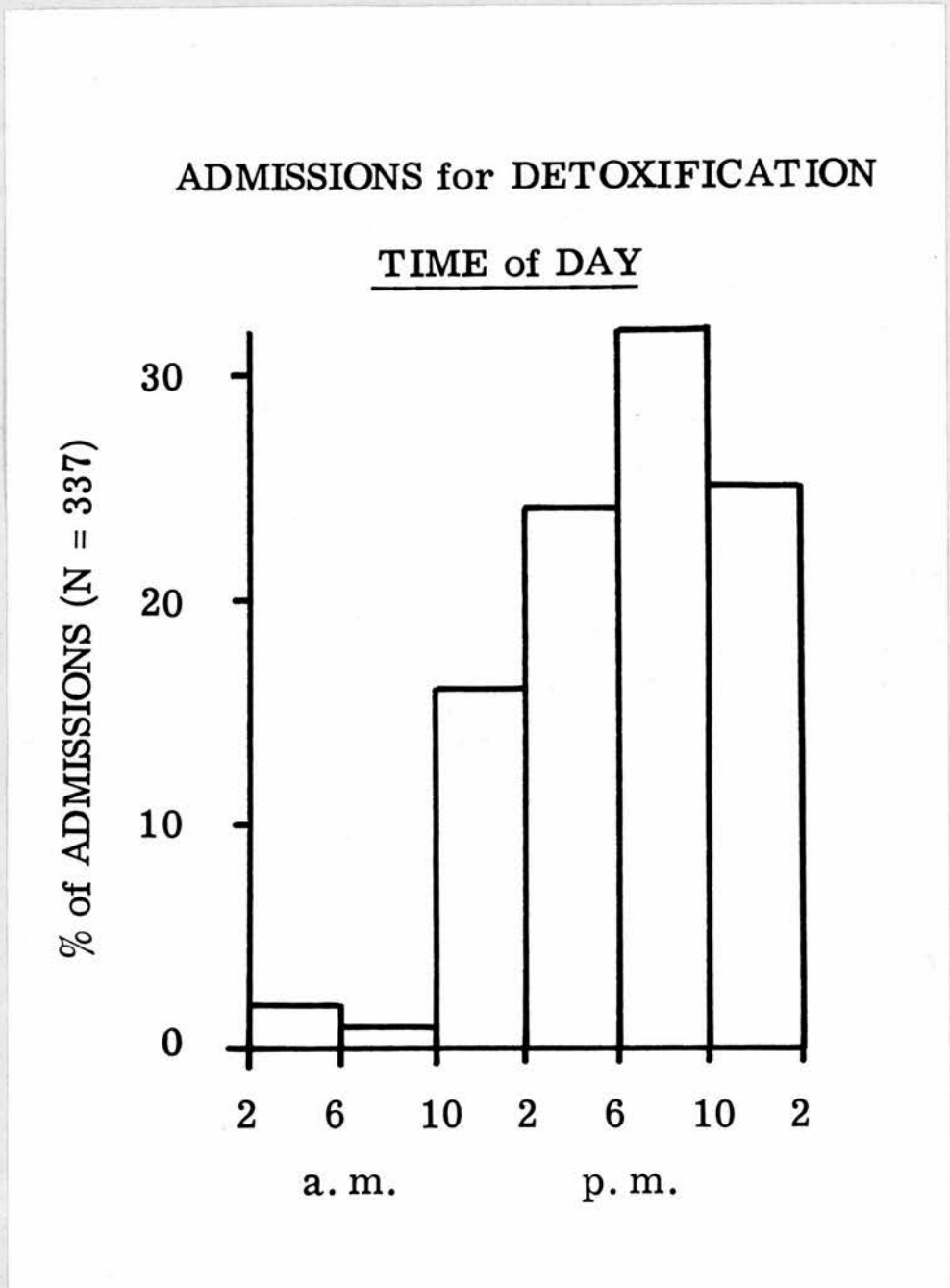


Fig. 5 shows the distribution of admissions by time of day; 72% of admissions were between 10 a.m. and 10 p.m. There were very few admissions during the night hours and no peak after 10 p.m. (the hour of closing of licensed premises in Scotland) reflecting the fact that these alcoholics become intoxicated outwith public houses:

Fig. 5



There were no differences in the day or time of admission between those admitted to the RPTC and those to the ADC.

SOURCE OF REFERRAL

Table 7.1 shows the source of referral for admission:

Table 7.1

DETOXIFICATION ADMISSIONS

SOURCE OF REFERRAL

	to RPTC (N = 195) %	to ADC (N = 142) %	Total (N = 337) %
Police	61	34	50
Self	23	45	32
Project Team	4	2	3
Other	4	18	10
(Not known)	(9)	(0)	(5)

It can be seen that proportionately more referrals were police-initiated in the RPTC compared with the ADC, whilst there were nearly twice as many self-referrals to the ADC as to the RPTC. One explanation of this is that some self-referrals presenting to the A & E and RPTC were not admitted and a greater tendency of the staff of the ADC to accept the patient's need for admission. Presumably these attitudes were known to the patients. Some patients however had far more of their year's eligibility for admission for detoxification during the time the project was located in the RPTC and it may be that these patients

had particular characteristics that made them more likely to be brought for detoxification by the police.

It is of interest that there were a greater proportion of self-referrals to the psychiatric hospital despite the fact that it is located some distance (about 2-3 miles) from the Grassmarket/Cowgate area where a high proportion of the men lived and drank. The Royal Infirmary is within half a mile of that area.

REASONS FOR ADMISSION

Ninety-five percent of all admissions were because the patient was intoxicated. The other 5% includes nine admissions in which the patient was intoxicated and had other drug poisoning, and six occasions on which the patient was certainly not intoxicated. There may have been other occasions on which the patient was somewhere on the borderline between 'intoxicated' and 'not intoxicated'. The definition of the terms is to a large degree subjective. It was evident that the diagnosis of an individual's state of intoxication is not always easy and cannot always quickly and easily be carried out by some hospital staff who may be unfamiliar with such conditions and have not learned that patients may have subjective withdrawal symptoms when not intoxicated.

'Horizontal' patients are more likely to be admitted than those 'vertical', as noted in the previous chapter, but cases were seen of patients able (because of their high

tolerance) to walk and speak almost coherently with blood alcohol levels of over 300 mgs. per 100 mls.

Blood alcohols were not routinely measured but of those that were the range was 240-420 mgs. per 100 mls.

READMISSIONS

Twelve percent of the 337 admissions were first admissions for detoxification.

Table 7.2

TIME SINCE MOST RECENT DISCHARGE

EXCLUDING FIRST ADMISSIONS

	to RPTC (N = 159) %	to ADC (N = 139) %	Total (N = 298) %
Within 24 hours	16	19	17
1-7 days	34	38	36
8 days - 1 month	30	19	24
1-2 months	13	12	12
2-3 "	2	4	3
3-4 "	4	2	3
4-5 "	1	4	2
5-6 "	1	1	1
6-9 "	1	0	1
9-12 "	0	1	1

Excluding these Table 7.2 shows that about one in six admissions were within 24 hours of discharge and about a half within one week. There is no difference in this between the RPTC and the ADC.

All admissions were voluntary and at no time was a patient compulsorily detained in hospital under the

provisions of the Mental Health Act. Two probands had one admission for detoxification each outwith the project (in Aberdeen and Ipswich).

MEDICAL DATA

In 96% of the admissions the patients were fully conscious on admission. The 10 instances in which they were not occurred in five patients:

Patient	GH :	coma level	I	once
"	IJ :	" "	I	twice
"	"	" "	II	"
"	"	" "	III	"
"	KL :	" "	III	once
"	MN :	" "	III	"
"	OP :	" "	III	"

In each of the 10 cases duration of coma was less than 12 hours. Gastric lavage was used on one occasion only (in the RPTC), on a patient (KL) who had taken a drug overdose in addition to being intoxicated. Intravenous fluids were never used.

As described in Chapter 5, 'The Detoxification Programme', a senior doctor could be called by the nursing staff for assistance in managing the patient, and this occurred in 37 (11%) of admissions. There was no difference in the rate or reason for so calling the doctor between the RPTC and the ADC.

Of these 37 occasions there was one instance each for coma and for severe vomiting and 11 because of aggressive behaviour by the patient.

Of the total of 37 occasions, 20 (69%) were accounted for by five patients (three, patients EF, QR, ST, with three occasions each; one, patient KL, with five occasions; one, patient UV, with six occasions).

Of the 11 calls for 'aggressive' behaviour, five were accounted for by one patient (UV), three by another (KL) and three other patients one call each.

The remaining 24 calls for other reasons were composed of the following:

RPTC: 20 instances (13 patients):

- 10 patients discharging themselves early against medical advice
- 1 query on discharging a patient because of full bed state in ward
- 4 to write up sedation for withdrawal symptoms
- 1 to write up sedation on patient known to be on anti-convulsants
- 1 patient with deep venous thrombosis in calf
- 3 not known

ADC: 4 instances (3 patients):

- 3 staff questioning whether to admit the patient because of his recent discharge
- 1 not known

Total of 24 instances:

- 11 concerning discharge
- 3 concerning admission
- 5 writing sedation
- 1 acute medical problem
- 4 not known

WITHDRAWAL SYMPTOMS

The relative incidence of withdrawal symptoms is given in Table 7.3. A detailed record of the symptoms present in each patient on each admission (Appendices G, H) was kept in the hope of identifying any particular syndromes or combination of symptoms:

Table 7.3

DETOXIFICATION ADMISSIONS (N = 337)

INCIDENCE OF WITHDRAWAL SYMPTOMS

EXCLUDING MISSING DATA

	Number known	Number present	% present
Dehydration	297	195	66
Flushing	299	165	55
Sweating	298	154	52
Shakes	301	153	51
Weakness	293	133	45
Miserable	293	127	43
Dyspepsia	295	124	42
Agitation	298	123	41
Tachycardia	300	79	26
Insomnia	300	76	25
Paraesthesia	293	71	24
Muscle Cramps	294	47	16
Confusion	302	39	13
Disorientation	304	22	7
Visual Hallucinations	303	14	5
Auditory Hallucinations	306	14	5
Paranoid Ideation	303	5	2
Epileptiform Convulsions	305	2	1

Some patients characteristically had no withdrawal symptoms and some many on each admission but there was little consistency or predictability concerning how each patient would present. In 30 (15%) of the RPTC admissions and 10 (7%) of the ADC admissions the patient showed no withdrawal symptoms. Of the total of 40 such admissions, 37 stayed only one day in the detoxification centre. The commonest combination of withdrawal symptoms were those of permutations of dehydration, flushing, sweating and shakes, occurring in 30-39% of all admissions. The low incidence (5%) of delirium tremens is in keeping with other present day findings.[1] In all these cases delirium tremens had been present on admission, and so it can be concluded that with adequate medication and good nursing care few cases should develop in hospital. It may however also be true that because of the relatively low duration of stay (see below) some patients were leaving hospital before such symptoms could develop.

DURATION OF STAY

Table 7.4 shows the duration of stay:

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[1] Pittman (1974) reported three instances of delirium tremens among 10,000 detoxification admissions, and Petersen (1974) claimed that of 50,000 admissions delirium tremens was 'virtually unknown'.

Table 7.4

LENGTH OF STAY

Number of days	in RPTC (N = 195) %	in ADC (N = 142) %	Total (N = 337) %
1	51	31	43
2	14	18	16
3	13	12	12
4	8	4	6
5	3	3	3
6	4	5	4
7	4	8	5
8	1	4	2
9	1	4	2
10	1	3	2
11	0	4	2
12	1	4	2
17	0	1	1
22	0	1	1
1 day	51	31	
2+ days	49	69	
1 day	51	31	
2-7 days	46	50	
8+ days	4	20	

	in RPTC days	in ADC days	Total days
Mean	2.5	4.2	3.2
Median	1	3	2
Mode	1	1	1

	in RPTC	in ADC	Total
Total days of stay	482	598	1080

Frequently patients discharged themselves before they were considered ready to leave. The maximum length of stay was decided to be seven days (unless otherwise indicated) but with a skewed distribution the mean was 3.2 days. It was possible to keep patients longer when the detoxification centre was located in the ADC. Fewer patients requested their own discharge, and the decision to leave was made by the project team and nursing staff without interference from physicians or other psychiatrists.

Not all the patients whose length of stay was one day were those who had no wish to stay to complete the detoxification process and wished to return to drink. Some may have been faring well and working, and had become drunk the previous night but, having been abstinent previously, would have no withdrawal symptoms the following morning. Others may similarly have been only minimally drunk when apprehended by the police. On not a few occasions a man insisted on leaving to return to work for fear of losing his job. On the other hand difficulties arose at times when one patient insisted on leaving and persuaded one or two other patients to leave with him, perhaps to share a bottle. Another factor in the RPTC affecting length of stay was the attitude of the staff towards the patients, the patients undoubtedly recognising the hostility directed towards them and leaving.

It is also true that once or twice if there was a number of beds in the ward full of 'detoxification'

patients, pressure would be put on the project team to discharge some to make room for newcomers. One other possible factor was the lack of 'ethos' about the detoxification centre. Due to its experimental nature and the lack of a separate unit from other patients with staff caring only for the detoxification patients, the latter did not know what was really expected of him in the sense of there being no patients setting an example. This does not mean that little effort was put into persuading the patients to stay - very often for instance, in the ADC, one of the nursing staff would spend several hours with a patient discussing with him his reasons for wishing to leave.

SEDATION PRESCRIBED

As referred to in Chapter 5, 'The Detoxification Programme', the drug most commonly used in the RPTC was chlorpromazine, either by injection or orally, and in the ADC chlormethiazole by mouth was the drug of choice. Chlordiazepoxide and paraldehyde were used rarely.

Table 7.5

SEDATION USED

(EXCLUDING NOT KNOWNS)

	in RPTC (N = 143) %	in ADC (N = 140) %	Total (N = 283) %
None	50	13	31
Some	50	87	69

Owing to difficulties in data collecting, it was not always possible to ascertain whether drugs prescribed in the RPTC were actually administered: multiple readmissions resulted in individual drug recording sheets being lost. However, adding all instances of drugs known to have been used, Table 7.5 shows that drugs were given more commonly in the ADC as compared with the RPTC. Overall sedation was used in at least 60% and probably in 70% of all admissions.

MEDICAL MORBIDITY

Besides the management of intoxication and detoxification, further information concerning other medical morbidity complicating any admissions has been extracted from the patients' case notes and the nursing notes. An instance of medical morbidity is defined as some pathological condition over and above intoxication and detoxification requiring the attention of nurses and/or doctors during the patient's stay in the detoxification centre. The number of episodes of medical morbidity are given in Table 7.6:

Table 7.6

NUMBER OF EPISODES OF MEDICAL MORBIDITY

	RPTC			ADC		RPTC + ADC		
	N	%	excluding not known %	N	%	N	%	excluding not known %
No. of admissions with no morbidity	121	62	65	63	44	184	55	56
No. of admissions with some morbidity	66	34	35	79	56	145	43	44
(Not known if morbidity)	(8)	(4)		(0)	(0)	(8)	(2)	

It will be seen from Table 7.6 that in one-third of the admissions to the RPTC morbidity was noted, whilst in the ADC morbidity was noted in over half of the occasions. The

overall morbidity for both places combined was, in general terms, about one episode of morbidity on every second admission.

The increased morbidity dealt with in the ADC would be partly due to the relatively longer stay of patients with thus an increased chance of pathology being revealed or detected, but it must also be pointed out that in the ADC the nurses' reports were more detailed and therefore more likely to include reference to medical morbidity. In both places these statistics can only be underestimates.

The main groups of morbidity were injuries such as lacerations (21 cases), soft tissue infections (13 cases) and verminous conditions (16 cases). There were 21 cases of respiratory disease and 21 with gastrointestinal disorder.

Among the more serious medical complications were those of pneumonia, pulmonary tuberculosis and chronic bronchitis, deep venous thrombosis and hypothermia. As documented in Chapter 7, there were instances of patients having taken drug overdoses in addition to being intoxicated, a few patients were comatose, and there were two episodes of convulsions during alcohol withdrawal.

The following is a more detailed breakdown of the episodes of medical morbidity, in some cases patients having more than one episode of morbidity on one admission:

Respiratory disorder

Of the three cases of pneumonia, two were lobar pneumonia and one bronchopneumonia. Two patients were found to have pulmonary tuberculosis and one with a past history of pulmonary tuberculosis was referred to a specialist because of reactivation of the disease. There were 11 episodes of acute bronchitis or acute exacerbation of chronic bronchitis. One patient was seen by a chest specialist following an abnormal X-ray which was initially thought to be due to occupational pneumoconiosis but later (post mortem) diagnosed as due to metastases from carcinoma of the liver. One patient was investigated for haemoptysis and referred to a chest physician (no respiratory disorder was diagnosed). There were other episodes of 'sore throat' and 'cold' dealt with.

Haematology

Many patients were found to have abnormal haematology such as hypochromic anaemia associated with alcoholism. One with severe macrocytic anaemia was investigated by sternal marrow puncture (diagnosis not established).

Injuries, soft tissue infections and skin conditions

In three cases of head injury the conscious level of the patient needed to be monitored. There were 21 patients who had simple injuries including lacerations, abrasions and

scalds requiring cleansing and dressing with antiseptics and sometimes requiring X-rays. There were 13 episodes of soft tissue infections including boils, carbuncles and cellulitis requiring antibiotics, cleaning and dressing and on one occasion referral for surgical incision of infected glands.

There were 16 episodes of verminous patients, 14 with pediculosis and two with scabies. These were treated with gammabenzine hexachloride and benzol benzoate. This total was made up by nine individuals, 24% of all those admitted.

There were many other cases of swollen and blistered feet, rashes and one patient had particularly troublesome psoriasis. Patients frequently had odd aches and pains, including headache, requiring analgesics (nine cases).

Gastrointestinal

There were 17 cases of gastritis requiring antacids. In addition there was one case of severe vomiting, and several (uncounted) cases of constipation requiring laxatives and diarrhoea requiring kaolin and morphine mixture. One patient was investigated for haematemesis (attributed to severe vomiting).

Urinary tract

In four instances urinary signs and symptoms were investigated and in one case a urinary tract infection treated. One patient was found to have glycosuria which required investigation for diabetes (diagnosis not established).

Cardiovascular system

There were three cases of hypotension which caused concern and one of a patient fainting. One patient was admitted with hypothermia. One patient had a deep venous thrombosis of the calf and was managed conservatively as he was thought to be unreliable at taking anticoagulants.

Ear, nose and throat

One patient required removal of impacted wax in his ears and another required referral to an ENT specialist where the pain in his ear and aural discharge was diagnosed as due to a post mastoidectomy complication. One patient was referred to an optician for provision of spectacles, another was investigated for an abnormality in the posterior chamber of the eye, and a third was treated with chloramphenicol drops and ointment for conjunctivitis.

Neurological system

Many patients had signs and symptoms of alcoholic peripheral neuritis and in some cases potassium or

analgestics were necessary for cramps in the abdominal or limb muscles.

Patients' behaviour and other

On three episodes nurses had difficulties with a patient drinking in the ward. On nine occasions disulfiram was prescribed by the ward and on one case citrated calcium carbimide. Besides management of withdrawal convulsions, one patient had epilepsy requiring stabilisation on phenobarbitone and primidone. On eight occasions the behaviour of the patient was aggressive to the extent that treatment with phenothiazines was necessary. In six cases insomnia required medication with nitrazepam.

Surgical appliances were needed in two cases - surgical boots for a patient with a previous compound fracture of the leg, and a truss for a patient with an incisional abdominal hernia.

Summary

Every patient who was admitted more than once for detoxification required at some time some medical or nursing attention and overall about every second admission had an episode of medical morbidity. As stated, these episodes are over and above the medical and nursing care needed during the process of withdrawal from alcohol. The detoxification process, with its associated

complications, and the medical morbidity, were easy to manage because the detoxification centres were located in hospitals.

CHAPTER 8

MORTALITY

MORTALITY

Eleven subjects (six probands and five controls) are known to have died since the time of their enrolment into the project. Every three months the Registrar General's death indices for Scotland and for England and Wales have been studied in Edinburgh and London to find out if any of the cohort had died. The causes of death were obtained from the patients' death certificates supplemented by any other known information. Death records for Scotland and for England and Wales have been examined for all of 1973 and 1974. In addition Scottish death records have been examined until 31st March 1975.

Table 8.1 gives the ages and causes of death of the 11 subjects. None of the probands died during admission for detoxification. Three probands died during the year of eligibility for detoxification: A, B and C in Table 8.1. Three more probands died after the anniversary of their enrolment: D, E and F. Four controls died during the 12 months following enrolment: G, H, I and J. One control died after the anniversary of his enrolment: K.

Table 8.1

AGES AND CAUSES OF DEATH

	Age (years)		Cause of death	Time after enrolment	Number of admissions for detoxification
A	58	Proband	Acute bronchitis, bronchopneumonia, bronchiectasis	10 days	0
B	60	Proband	Cardiac failure, hepatic failure, hepatic cirrhosis, chronic bronchitis	39 days	4
C	62	Proband	Uraemia, acute tubular necrosis, bronchopneumonia due to multiple injuries	292 days	4
D	40	Proband	Pulmonary tuberculosis, chronic alcoholism	1 year, 16 days	-
E	52	Proband	Carcinoma of the breast, hepatic and pulmonary metastasis	1 year, 18 days	-
F	53	Proband	Asphyxia due to hanging, depression (suicide)	1 year, 340 days	-
G	64	Control	Subarachnoid haemorrhage	65 days	-
H	54	Control	Cerebrovascular accident	123 days	-
I	60	Control	Multiple injuries, road accident	217 days	-
J	41	Control	Acute alcoholism, barbiturate poisoning (circumstances not known)	323 days	-
K	54	Control	Pulmonary congestion and oedema, congestive cardiac failure, chronic alcoholism	2 years, 162 days	-

Table 8.2 compares the mortality of the cohort during 1973-74 with that of Scottish males (Registrar General, 1974).

Table 8.2

MORTALITY RATES

Age (years)	Number of cohort alive on 1/1/1973	Number of deaths of cohort in 1973	Cohort death rate per 1,000 1973	Number of cohort alive on 1/1/1974	Number of deaths of cohort in 1974	Cohort death rate per 1,000 1974	Scottish males death rate per 1,000 1973
35-44	28	0	0	28	2	71.4	2.9
45-54	32	0	0	32	2	62.5	9.3
55-64	21	3	142	18	2	111.1	24.5
65-74	7	0	0	7	0	0	58.4
			142.9			245	95.2

From Table 9.2

Standard mortality ratio 1973 = $\frac{142.9}{95.2}$ = 150%

Standard mortality ratio 1974 = $\frac{245}{95.2}$ = 257%[1]

In the 55-64 age group

Standard mortality ratio 1973 = $\frac{142.9}{24.5}$ = 583%

Standard mortality ratio 1974 = $\frac{111.1}{24.5}$ = 453%

[1] Scottish death rate for 1973 is latest available but 1974 figure is unlikely to be appreciably different from 1973.

The information obtained at the enrolment interview of the men who died was studied to elicit any common characteristics. Positive findings are given in Table 8.3.

Table 8.3

	Subjects who died (N = 11) N	%	Subjects still alive (N = 89) N	%	
25 or more convictions in lifetime for drunkenness offences, at enrolment	9	82	28	32	$\chi^2 = 8.60$ df = 1 p 0.01
Stated at enrolment: 'drink interfering with life' for 14 or more years	11	100	48	54	$\chi^2 = 6.79$ df = 1 $p < 0.01$

In summary, over the period studied the cohort had a death rate of about twice the general population. Those who died appeared to have been alcoholics for at least 14 years and to have a high number of convictions for drunkenness.

CHAPTER 9

EVALUATION

EVALUATION

AT THE END OF THE EXPERIMENTAL YEAR

Discussion of the effect of adding a detoxification service to the Regional Poisoning Treatment Centre and to the Andrew Duncan Clinic is given in Chapter 6 and further evaluation of the second aim of the project, namely the effectiveness of this facility for drunken offenders, entailed compilation of penal, medical and rehabilitative data before, during and (to a limited extent) after the experimental year, supplemented by information obtained by questionnaire from the subjects themselves.

a) DATA ON PENAL, MEDICAL AND REHABILITATIVE ASPECTS

To assess the effectiveness of a detoxification and associated rehabilitative service for alcoholic offenders, it was necessary first to determine whether the management of the proband group could be successfully transferred from the penal system to a medical one and to compare the outcome of the probands with the control group.

The progress of each of the proband and control subjects was monitored with periodic updating of data obtained from records kept by the court, prison, hospitals and hostels. The information collected was displayed on wall charts to assist the project team to know where any

subject was at any one time, and in order to facilitate the enumeration of the data.

Penal data

Data from court records was extracted with increasing experience without much difficulty. 'Court appearances' in the data is synonymous with 'convictions' in the sense that all court appearances resulting in 'not guilty' verdicts, have been omitted. In fact virtually no drunkenness offences attracted other than a 'guilty' plea. If there were two convictions at one court appearance for a breach of the peace and another drunkenness offence (the two charges being preferred for the same offence), this has been categorised as 'breach of the peace' only. If there had been one court appearance for a non-drunkenness offence together with a drunkenness offence, these have been categorised as a non-drunkenness offence only, the more serious charge being assumed to absorb the lesser.

Offences have been graded into three groups:

(1) 'Drunk and incapable' or contravention of Licensing (Scotland) Act 1903, section 70, which together with those in (2) comprise 'drunkenness offences'.

(2) Other drunkenness offences, namely:
Drunk and disorderly (outside Edinburgh).
Breach of the peace (in Burgh Court).
'Nuisance': contravention of Edinburgh Corporation Order Confirmation Act 1967, section 448. (This Act is hereafter referred to as ECO 1967.)
'Begging': ECO 1967, section 483(1).

'Vagrant': ECO 1967, section 483(2).
Trespass (Scotland) Act 1865, section 3.
'Obstruction': ECO 1967, section 464.
'Interfering with refuse': ECO 1967, section 474.

(3) Non-drunkenness offences, namely:
Assault.
Police assault (Police Scotland Act 1967, section 41).
Indecent exposure.
Malicious mischief.
'Known thief' (ECO 1967, section 482).
Theft.
Housebreaking.
Burglary.
Breach of the peace (in Sheriff Court).

'Breach of the peace' is usually dealt with in the Burgh Court and only more serious cases of this charge in the Sheriff Court. In the present cohort any charge of 'breach of the peace' in (2) above almost invariably meant that the subject was drunk. It was not considered worth the laborious task of attempting to elicit the few cases when such a person was not drunk; if not it is highly likely he had been drinking.

Many of the non-drunkenness offences may well have been committed under the influence of drink or even to the extent of the subject being drunk, but it was thought wise to separate the two groups clearly and no difficulty was found in dichotomising the offences. Only one offence proved a problem, viz. ECO 1967, section 395, which makes it an offence to refuse to pay a taxi fare. It was not thought that this could reasonably be put in the 'drunkenness' group but was hardly serious enough to be

included with housebreaking and police assault. The offence was not included in either group.

The reason for separating the offences into three categories is that the agreement with the police and prosecuting authorities was that no proband should be charged with being 'drunk and incapable' (in Edinburgh) and that discretion should be applied in the case of other offences committed whilst drunk, i.e. if in the circumstances taking the patient to the detoxification centre was the most appropriate action. It would then be possible to see whether there had been changes not just as regards 'drunk and incapable' but on other drunkenness offences and on non-drunkenness offences.

The prison records were less efficiently maintained and cumbersome to negotiate, matters not being helped by some individuals having given several dates of birth or having aliases. One proband was in fact nearly enrolled twice into the project when he appeared at the second time with an assumed name (or perhaps his real name, we never found out which). Neither of his court records on their own was particularly bad but put together, this individual would probably have been more severely dealt with by the magistrate.

Another control had four names, none of them apparently his own: "Sure, my mother would die if she read it in the papers."

The following data compares the progress of 47 proband and 44 control subjects in the 12 months prior to and subsequent to enrolment into the study. Five probands are not included as they did not complete a year since enrolment whilst still participating in the project. Two probands were withdrawan due to complete lack of co-operation with the aims of the project (after 23 and 315 days, see page 147), and three probands died (after 10, 23 and 39 days). Four controls are likewise excluded, having died after 65, 123, 217 and 323 days.

Each individual was given a score compared with the previous year on each of the variables measured. The scores were subjected to Student's 't' test to find the significance of the variation from zero for the probands in the year after enrolment compared with the year before, and the same with the controls. 't' was then calculated to find the significance of the difference between probands and controls.

Table 9.1

a) NUMBER OF COURT APPEARANCES FOR 'DRUNK AND INCAPABLE'

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47 per 100 probands	189 402	20 43	- 89%	t = 4.124 df = 46 p < 0.001
Controls: N = 44 per 100 controls	107 243	156 354	+ 46%	t = 1.536 df = 43 NS

t = 4.127; df = 89; p < 0.001

b) NUMBER OF COURT APPEARANCES FOR ALL DRUNKENNESS OFFENCES

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47	239	57		t = 4.250
per 100 probands	508	121	- 76%	df = 46
				p < 0.001
Controls: N = 44	154	197		t = 1.289
per 100 controls	350	448	+ 28%	df = 43
				NS

t = 4.0625; df = 89; p < 0.001

c) NUMBER OF COURT APPEARANCES FOR ALL OFFENCES

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47	274	94		t = 4.187
per 100 probands	583	200	- 66%	df = 46
				p < 0.001
Controls: N = 44	183	213		t = 0.861
per 100 controls	416	484	+ 16%	df = 43
				NS

t = 3.7067; df = 89; p < 0.001

Of the 20 charges for drunk and incapable in the year of study for the probands (Table 9.1a) three were outwith Edinburgh (where the patient no longer had 'immunity' from prosecution) and 17 were as a result of 'accidental' prosecutions, the police not knowing the patient was on the 'detoxification list' (though some patients intentionally did not reveal this when they could have done so, see page 139).

Table 9.2

a) NUMBER OF DAYS IN PRISON FOR 'DRUNK AND INCAPABLE'

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47 per 100 probands	748 1592	46 98	- 94%	t = 2.4777 df = 46 p < 0.02
Controls: N = 44 per 100 controls	255 580	563 1280	+ 121%	t = 1.8940 df = 43 NS

t = 3.0531; df = 89; p < 0.005

b) NUMBER OF DAYS IN PRISON FOR ALL DRUNKENNESS OFFENCES

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47 per 100 probands	1256 2672	348 740	- 72%	t = 2.7389 df = 46 p < 0.01
Controls: N = 44 per 100 controls	707 1607	829 1884	+ 17%	t = 0.5378 df = 43 NS

t = 2.5006; df = 89; p < 0.02

c) NUMBER OF DAYS IN PRISON FOR ALL OFFENCES

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47 per 100 probands	2151 4577	1039 2211	- 52%	t = 3.1836 df = 46 p < 0.005
Controls: N = 44 per 100 controls	1422 3232	1150 2614	- 19%	t = 0.7735 df = 43 NS

t = 1.6035; df = 89; NS

The amount of time spent in prison as a result of a court appearance depends upon several variables - the individuals' number of previous convictions and how recent they were, the sentencing practice of the individual magistrate and the ability of the offender to pay all or some of the fine imposed. Table 9.3 therefore gives data on number of times in prison as opposed to days in prison.

Table 9.3

a) NUMBER OF TIMES IN PRISON FOR 'DRUNK AND INCAPABLE'

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47	84	6		t = 2.8553
per 100 probands	179	13	- 93%	df = 46
				p<0.01
Controls: N = 44	27	77		t = 2.3021
per 100 controls	61	175	+ 185%	df = 43
				p<0.05

t = 3.6423; df = 89; p<0.001

b) NUMBER OF TIMES IN PRISON FOR ALL DRUNKENNESS OFFENCES

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47	112	31		t = 2.8524
per 100 probands	238	66	- 72%	df = 46
				p<0.01
Controls: N = 44	60	101		t = 1.8565
per 100 controls	136	230	+ 68%	df = 43
				NS

t = 3.3559; df = 89; p<0.001

c) NUMBER OF TIMES IN PRISON

FOR ALL OFFENCES

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47 per 100 probands	134 285	47 100	- 65%	t = 3.0666 df = 46 p< 0.005
Controls: N = 44 per 100 controls	78 177	112 254	+ 44%	t = 1.4259 df = 43 NS

t = 3.2191; df = 89; p< 0.005

It is seen from Table 9.3 that the number of times, as opposed to days, in prison has also fallen greatly in the proband group. Tables 9.1, 9.2 and 9.3 thus show the desired large fall in the number of court appearances, times in prison and days in prison for drunk and incapable for the probands, and it is noted that this extends to all drunkenness offences and even if other offences are included. The controls show no significant change from their previous year. The slight increase in the number of times the controls went to prison for being drunk and incapable in the year after enrolment is probably due to an 'odd' year before enrolment for the group, they then having fewer offences than would be expected. It will be seen for instance that the number of times they went to prison in their year after enrolment was similar to the number in the probands year before enrolment.

THERE HAS BEEN AN OVERALL SAVING IN THE COURSE OF 12 MONTHS, AMONGST 47 PROBANDS, OF SOME 180 COURT APPEARANCES, 87 RECEPTIONS INTO PRISON AND 1,112 DAYS IN PRISON.

Medical and rehabilitative aspects

The following tables compare the subjects' progress in the different treatment settings. The facilities for rehabilitation in Edinburgh are described on page 111. Hostel class I (rehabilitative) is Thornybauk Hostel which has the specific aim of rehabilitating homeless alcoholic men. Hostels class II include Vanburgh Place and Rankeillor Street (Church of Scotland) Hostels which receive such men along with others but which are not considered to have the same degree of 'clear therapeutic purpose' as Thornybauk Hostel. The latter hostel opened in January 1974 and was not available for any subjects in their year before enrolment.

Psychiatric hospitals include all those known to have admitted subjects in the period of the study. The records of all admissions to psychiatric hospitals in the area, namely the Royal Edinburgh Hospital, Rosslynlee Hospital and Bangour Village Hospital were studied. In addition records were studied of non-psychiatric hospitals in the area, namely the Royal Infirmary, Western General Hospital, City Hospital and all others in the City of Edinburgh. The records from the hostels were understandably not as well kept as in the hospitals. Nevertheless they were believed to be reasonably accurate as they usually agreed with the information on admissions and discharges known to the project team from their own records.

In Thornybauk Hostel seven probands (15 per 100 probands) spent 615 days (1,308 per 100 probands) in their year after enrolment. No control was admitted there in his year after enrolment.

The total days spent by the probands in the detoxification centre was 1,053 (2,240 per 100 probands). Tables 9.4 show the number of days spent in different therapeutic situations.

Table 9.4

a) NUMBER OF DAYS IN TREATMENT

HOSTELS CLASS II (RESIDENTIAL)

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47 per 100 probands	492 1047	711 1513	+ 44%	t = 0.6087 df = 46 NS
Controls: N = 44 per 100 controls	83 189	156 354	+ 88%	t = 1.7087 df = 43 NS

t = 0.3764; df = 89; NS

b) NUMBER OF DAYS IN TREATMENT

PSYCHIATRIC HOSPITALS (excluding Detoxification Unit)

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47 per 100 probands	142 302	1005 2138	+ 608%	t = 2.9603 df = 46 p<0.005
Controls: N = 44 per 100 controls	500 1136	269 611	- 46%	t = 0.6999 df = 43 NS

t = 2.4384; df = 89; p<0.02

c) NUMBER OF DAYS IN TREATMENT

Hostels (Rehabilitative & Residential)
+ Psychiatric Hospitals
+ Detoxification Unit

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47 per 100 probands	634 1349	3375 7200	+ 434%	t = 4.6102 df = 46 p< 0.001
Controls: N = 44 per 100 controls	583 1325	425 966	- 27%	t = 0.4691 df = 43 NS

t = 4.1188; df = 89; p< 0.001

d) NUMBER OF DAYS IN TREATMENT

Rehabilitative Hostel
+ Psychiatric Hospitals
+ Detoxification Unit

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47 per 100 probands	142 302	2664 5687	+ 1782%	t = 4.5863 df = 46 p< 0.001
Controls: N = 44 per 100 controls	500 1136	269 611	- 46%	t = 0.6999 df = 43 NS

t = 4.1757; df = 89; p< 0.001

e) NUMBER OF DAYS IN TREATMENT

Rehabilitative Hostel
+ Psychiatric Hospitals

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47 per 100 probands	142 302	1620 3447	+ 1041%	t = 3.5023 df = 46 p< 0.005
Controls: N = 44 per 100 controls	500 1136	269 611	- 46%	t = 0.6999 df = 43 NS

t = 3.1146; df = 89; p< 0.005

f) NUMBER OF DAYS IN TREATMENT

Hostels (Rehabilitative & Residential) + Psychiatric Hospitals

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47	634	2331		t = 3.3677
per 100 probands	1349	4960	+ 368%	df = 46
				p<0.005
Controls: N = 44	583	425		t = 0.4691
per 100 controls	1325	966	- 27%	df = 43
				NS

t = 2.9781; df = 89; p<0.005

Table 9.5

NUMBER OF DAYS IN NON-PSYCHIATRIC HOSPITALS

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47	213	267		t = 0.2783
per 100 probands	453	568	+ 25%	df = 46
				NS
Controls: N = 44	308	258		t = 0.3255
per 100 controls	700	586	- 16%	df = 43
				NS

t = 0.4198; df = 89; NS

The number of days spent in treatment by the probands has increased wherever special attempts were made by the project team to secure some rehabilitative management for the men after detoxification. Their days spent in residential (class II) hostels and in general hospitals remain the same. The controls continued as before.

In all combinations of forms of treatment, the days spent in care by the probands have increased to a very highly significant extent. Obviously the days spent in combinations which include the detoxification unit have increased (Table 9.4c and d), but the increase also applies to those combinations in which the detoxification unit is excluded (Tables 9.4e and f).

The number of admissions to the institutions providing care(as opposed to the days spent in them) is shown in the following tables.

Table 9.6

a) NUMBER OF ADMISSIONS TO HOSTEL CLASS II

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47	18	18		t = 0 df = 46
per 100 probands	38	38	0	NS
Controls: N = 44	4	13		t = 1.7113 df = 43
per 100 controls	9	30	+ 225%	NS

t = 0.9237; df = 89; NS

b) NUMBER OF ADMISSIONS

TO PSYCHIATRIC HOSPITALS

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47	10	34		t = 2.5378
per 100 probands	21	72	+ 240%	df = 46
				p<0.02
Controls: N = 44	14	6		t = 1.0925
per 100 controls	32	14	- 57%	df = 43
				NS

t = 2.6292; df = 89; p<0.02

c) NUMBER OF ADMISSIONS

TO HOSTEL I + PSYCHIATRIC HOSPITALS

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47	10	41		t = 2.9134
per 100 probands	21	87	+ 310%	df = 46
				p<0.01
Controls: N = 44	14	6		t = 1.0925
per 100 controls	32	14	+ 57%	df = 43
				NS

t = 2.9856; df = 89; p<0.005

d) NUMBER OF ADMISSIONS

TO HOSTEL I + HOSTEL II

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47	18	25		t = 1.1674
per 100 probands	38	53	+ 39%	df = 46
				NS
Controls: N = 44	4	13		t = 1.7113
per 100 controls	9	30	+ 225%	df = 43
				NS

t = 0.0370; df = 89; NS

e) NUMBER OF ADMISSIONS

TO HOSTEL II + PSYCHIATRIC HOSPITALS

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47	28	52		t = 2.6265
per 100 probands	60	53	+ 86%	df = 46
				p<0.02
Controls: N = 44	18	19		t = 0.1042
per 100 controls	41	43	+ 6%	df = 43
				NS

t = 1.6507; df = 89; NS

f) NUMBER OF ADMISSIONS

TO HOSTEL I + HOSTEL II + PSYCHIATRIC HOSPITALS

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47	28	59		t = 3.1882
per 100 probands	60	126	+ 111%	df = 46
				p<0.005
Controls: N = 44	18	19		t = 0.1042
per 100 controls	41	43	+ 6%	df = 43
				NS

t = 2.1937; df = 89; p<0.05

The success of the referral procedure is seen also in Tables 9.6. The number of admissions (rather than days spent in the establishment to which the patient was referred) has increased with respect to rehabilitative hostels and psychiatric hospitals, and in combinations including these establishments. It might be stressed again here that the project team themselves never intended to treat the patients for their alcoholism. Instead the aim was to provide a non-penal detoxification facility where the patients could be assessed and referred to any appropriate treatment agency available. It appears that the project was successful in achieving this aim.

EPISODES OF DRUNKENNESS

Table 9.7

NUMBER OF DAYS IN TREATMENT*

+ Number of days in prison for All Offences

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47	2785	4414		t = 2.8985
per 100 probands	5926	9411	+ 59%	df = 46
				p< 0.01
Controls: N = 44	2005	1575		t = 0.8459
per 100 controls	4557	3580	- 21%	df = 43
				NS

t = 2.6453; df = 89; p<0.01

*'Treatment' includes days in all of psychiatric hospitals, hostels (rehabilitative and residential) and detoxification unit.

Table 9.7 combines the number of days in all forms of 'treatment' (here meaning medical/rehabilitative management, Table 9.4c) with days in penal management for the different classes of offences (Table 9.2c). The tables show that in the year after enrolment for the probands the amount of time spent in combined penal and medical management has increased to a highly significant degree.

With the type of individual forming the cohort under study, it was recognised that any measures of quantity and frequency of drinking would not be possible to obtain with any degree of accuracy for a prospective period of one year and certainly not retrospectively. Some questions on the drinking behaviour of the individuals were included in the

enrolment and evaluation questionnaires and follow-up data is presented in paragraph b) below. In addition figures in Table 9.7 could be interpreted as 'number of definitely known dry days' in that the individuals were definitely not drinking whilst in these establishments. The probands therefore have a highly significant increase in the number of definitely known 'dry days'.

Table 9.8

a) NUMBER OF DETOXIFICATION ADMISSIONS

+ Number of Court Appearances for 'Drunk and Incapable'

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47 per 100 probands	189 402	343 730	+ 82%	t = 2.3411 df = 46 p < 0.05
Controls: N = 44 per 100 controls	107 243	156 354	+ 46%	t = 1.536 df = 43 NS

t = 1.3263; df = 89; NS

b) NUMBER OF DETOXIFICATION ADMISSIONS

+ Number of Court Appearances for All Drunkenness Offences

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47 per 100 probands	239 508	390 808	+ 59%	t = 2.0409 df = 46 p < 0.05
Controls: N = 44 per 100 controls	154 350	197 448	+ 28%	t = 1.289 df = 43 NS

t = 1.1872; df = 89; NS

Tables 9.8a and b show the number of times the subjects were handled penally and medically for episodes of drunkenness and demonstrate that the probands were not becoming drunk to any significant extent more often in the year after enrolment than they had done in the previous year. In other words the data tends to refute any suggestion that the probands saw their participation in the project as a 'licence to get drunk'.

The figures for detoxification admissions include those self-referred and police-initiated. Some of those self-referred (and some police-initiated admissions) were certainly less drunk than individuals are when arrested for drunkenness offences. Had admissions for detoxification of those drunk to the same degree as those arrested only been used, the figures for the probands' post-enrolment year would be less and the significance not even reach the 5% level.

Furthermore the data in these tables is heavily influenced by the few individual probands with a large number of admissions for detoxification. Tables 9.8c and d exclude two probands who had 39 and 36 admissions respectively, and also the two controls with the highest number of court appearances for 'drunk and incapable' (20 and 14) and for all drunkenness offences (18 and 14). It is seen that the percentage increases are halved for the probands and are not statistically significant.

Table 9.8

c) NUMBER OF DETOXIFICATION ADMISSIONS + Number of Court Appearances[1] for 'Drunk and Incapable'

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 45 per 100 probands	188 418	264 586	+ 40%	t = 1.9372 df = 44 NS
Controls: N = 42 per 100 controls	100 238	115 274	+ 15%	t = 0.7005 df = 41 NS

t = 1.2686; df = 85; NS

d) NUMBER OF DETOXIFICATION ADMISSIONS + Number of Court Appearances[1] for All Drunkenness Offences

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 45 per 100 probands	235 522	307 682	+ 31%	t = 1.4232 df = 44 NS
Controls: N = 42 per 100 controls	145 345	156 371	+ 8%	t = 0.4415 df = 41 NS

t = 0.9509; df = 85; NS

[1] Excluding two probands and two controls with highest scores (see text).

The data on the number of known episodes of drunkenness (number of court appearances for 'drunk and incapable' and also for all drunkenness offences, plus admissions for detoxification in the year after enrolment for the probands) in the year before and the year after enrolment, have also been studied in relation to the numbers of 'days at risk'.

The number of 'days at risk' for each proband and control subject was calculated by subtracting from 365 the number of days in which the subject was in prison (for any offence) and was hence not at liberty to drink.

Each subject was then given a score of the number of known episodes of drunkenness multiplied by 365 and divided by the number of 'days at risk'. For each subject the score for the year before enrolment was subtracted from that for the year after enrolment to give a final score for the difference in the number of known episodes of drunkenness taking into account the days at risk.

The following is an example of the method of calculation: Patient 0067 (proband):

		Year Before Enrolment	Year After Enrolment
(1)	No. of days in prison	101	9
(2)	No. of days at risk: 365-(1)	264	356
(3)	No. of court appearances for 'drunk and incapable':	15	0
(4)	No. of admissions for detoxification	0	16
(5)	No. of known episodes of drunkenness: (3) + (4)	15	16
(6)	Episodes of drunkenness per 'days at risk': (5) x $\frac{365}{(2)}$	20.7	16.4

Difference between 2 experimental years = -4.3

The final scores of adjusted number of drunken episodes were then subjected to Student's "t" test in the same manner as described on page 189.

Table 9.8e

Adjusted Number of Episodes of Drunkenness

(court appearances for 'drunk and incapable' and detoxification admissions) adjusted for 'days at risk'

		Episodes in year after enrolment -Episodes in year before enrolment	
Probands (N=47)	Mean SD	1.29 17.60	t=0.5023 df=46 NS
Controls (N=44)	Mean SD	2.14 8.94	t=1.5871 df=43 NS

t = 0.2872; df = 89; NS

Table 9.8f

Adjusted Number of Episodes of Drunkenness

(court appearances for all drunkenness offences and detoxification admissions)

		Episodes in year after enrolment -Episodes in year before enrolment	
Probands (N=47)	Mean SD	0.82 18.46	t=0.3041 df=46 NS
Controls (N=44)	Mean SD	2.28 9.50	t=1.5908 df=43 NS

t = 0.4688; df = 89; NS

Tables 9.8e and f show that, taking 'days at risk' into consideration, the increased number of episodes of drunkenness in the experimental year is less among the probands than among the controls, but in neither group does the difference in the years before and after enrolment reach statistical significance. Furthermore there is no difference between the probands and controls. The higher standard deviation in the proband group (nearly double that of the control group) suggests that the latter group were more consistent in their drinking habits between the 2 years, whilst among the probands there are probably 2 small groups of men with high individual scores who did respectively 'well' by having fewer episodes of drunkenness or 'worse' by becoming drunk more often (further comment on page 273).

As well as studying the number of episodes of drunkenness resulting in police arrest or hospital admission, it is useful to examine the number of days spent in penal and medical resources as a result of these episodes of drunkenness.

Table 9.9

a) NUMBER OF DAYS IN DETOXIFICATION UNIT
+ Number of days in prison for 'Drunk and Incapable'

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47 per 100 probands	748 1592	1099 2339	+ 47%	t = 1.1053 df = 46 NS
Controls: N = 44 per 100 controls	255 580	563 1280	+ 121%	t = 1.8940 df = 43 NS

t = 0.0305; df = 89; NS

b) NUMBER OF DAYS IN DETOXIFICATION UNIT
+ Number of days in prison for All Drunkenness Offences

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47 per 100 probands	1256 2672	1401 2981	+ 12%	t = 0.3951 df = 46 NS
Controls: N = 44 per 100 controls	707 1607	1150 1884	+ 17%	t = 0.5378 df = 43 NS

t = 0.0087; df = 89; NS

Table 9.10

a) NUMBER OF POLICE-REFERRED DETOXIFICATION ADMISSIONS*

+ Number of Court Appearances for 'Drunk and Incapable'

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47	189	180		t = 0.3178
per 100 probands	402	383	- 5%	df = 46
				NS
Controls: N = 44	107	156		t = 1.536
per 100 controls	243	354	+ 46%	df = 43
				NS

t = 1.3028; df = 89; NS

b) NUMBER OF POLICE-REFERRED DETOXIFICATION ADMISSIONS*

+ Number of Court Appearances for All Drunkenness Offences

	In the year before enrolment	In the year after enrolment	% change	
Probands: N = 47	239	217		t = 0.5980
per 100 probands	508	462	- 9%	df = 46
				NS
Controls: N = 44	154	197		t = 1.289
per 100 controls	350	448	+ 28%	df = 43
				NS

t = 1.3100; df = 89; NS

*160 for N = 47; 340 per 100 probands.

Tables 9.9a and b show that the number of days spent in hospital and in prison as a result of drunkenness among the probands has not increased. Tables 9.10a and b combine those admissions for detoxification initiated by the police with the number of court appearances for drunkenness offences and it can be seen that the police did not have any more work (in admitting or charging probands for drunkenness), nor any less, when compared with the controls.

A summary of the degrees of significance of the various measures in this paragraph follows:

Table 9.11

SUMMARY OF DEGREE OF STATISTICAL SIGNIFICANCES OF TABLES 9.1 TO 9.10

	Significance from zero p<		Probands v. Controls
	Probands	Controls	
Court Appearances:			
Drunk and Incapable	0.001	NS	0.001
All Drunkenness Offences	0.001	NS	0.001
All Offences	0.001	NS	0.001
Number of days in prison:			
Drunk and Incapable	0.02	NS	0.005
All Drunkenness Offences	0.01	NS	0.02
All Offences	0.005	NS	NS
Number of times in prison:			
Drunk and Incapable	0.01	0.05	0.001
All Drunkenness Offences	0.01	NS	0.001
All Offences	0.005	NS	0.005
Number of days in psychiatric hospitals	0.005	NS	0.02
Number of days in hostels II	NS	NS	NS
Number of days in other hospitals	NS	NS	NS
Days in treatment:			
a) Hostels I & II, psychiatric hospitals, detoxification unit	0.001	NS	0.001
b) Hostels I, psychiatric hospitals, detoxification unit	0.001	NS	0.001
c) Hostels I, psychiatric hospitals	0.005	NS	0.005
d) Hostels I & II, psychiatric hospitals	0.005	NS	0.005

Table 9.11 (contd.)

	Significance from zero p<		Probands v. Controls
	Probands	Controls	
No. of admissions:			
Hostel II	NS	NS	NS
Psychiatric hospitals	0.02	NS	0.02
Hostel I + psychiatric hospitals	0.01	NS	0.005
Hostel I + hostel II	NS	NS	NS
Hostel II + psychiatric hospitals	0.02	NS	NS
Hostel I, hostel II + psychiatric hospitals	0.005	NS	0.05
Days in treatment + days in prison for Drunk and Incapable	0.001	NS	0.01
Days in treatment + days in prison for All Drunkenness Offences	0.005	NS	0.02
Days in treatment + days in prison for All Offences	0.01	NS	0.01
Number of detoxification admissions + court appearances for Drunk and Incapable	0.05	NS	NS
Number of detoxification admissions + court appearances for All Drunkenness Offences	0.05	NS	NS
Days in detoxification unit + days in prison for Drunk and Incapable	NS	NS	NS
Days in detoxification unit + days in prison for All Drunkenness Offences	NS	NS	NS
Number of police-referred detoxification admissions + number of court appearances for Drunk and Incapable	NS	NS	NS
Number of police-referred detoxification admissions + number of court appearances for All Drunkenness Offences	NS	NS	NS

b) DATA FROM EVALUATION QUESTIONNAIRES

Methods

When each man had completed 12 months from the date of his enrolment, the project team tried to interview him and ask him the questions on the evaluation questionnaire (Appendix J). It was not easy to locate many of the men. The research workers spent months checking court lists and admissions to the local prison, leaving lists of the people being sought at the Central Police Charge Office, at the Information Centre in the Grassmarket, at the surgery attended by many of the Grassmarket men, asking for information from lodging house superintendents, relatives and neighbours, and investigating every possible place where the subjects might be known, sometimes going back to the same places over and over again in the hope that someone might be found. One man's house was visited at all hours eight times before he finally was interviewed on a Sunday morning. Eventually 85 of the 100 men in the cohort were traced by the time the search was concluded three months after the last subject had completed his year in the project. This figure includes seven men who died during the year after enrolment, so that there were 78 completed questionnaires available for analysis.

Characteristics of missing subjects

The 15 men not found consisted of seven probands and eight controls. Five of these probands were never admitted for detoxification and never attended the out-patient clinic,

and thus, together with the eight controls, were not seen again after enrolment. Prior to enrolment 11 (73%) of the missing men when enrolled had stayed in Edinburgh for less than nine months and another two (13% for less than two years. The remaining two men were native to Edinburgh, but one of them had telephoned early in the study from Aberdeen, where he had obtained a job, to demand that the project team not contact him any more as it upset his mother to be reminded of his drinking problem. He refused to give his address in Aberdeen, and the team had to agree to abide by his wishes.

None of the missing men was married at the time of enrolment and two-thirds of them were aged 45 or under, mean age 43.1 (standard deviation 8.9). The mean age of the rest of the enrolment cohort was 49.6 (standard deviation 11.9). Sixty-seven percent of the missing men were homeless on enrolment, living in common lodging houses, sleeping rough or in prison, compared with 59% of the rest of the enrolment cohort ($\chi^2 = 0.08$; df = 1; NS). Sixty percent of the missing men were employed when enrolled or had worked for part of the previous year, while 40% of the rest of the cohort had worked during the past year ($\chi^2 = 1.34$; df = 1; NS). Fifty-three percent of the missing men had never been unemployed for as long as one year, compared with only 17% of the enrolment cohort ($\chi^2 = 8.06$; df = 1; $p < 0.01$). The missing men on the whole did not appear to have slipped as far down the incline of alcoholism as the other men. Seventy-three percent of

them had never had delirium tremens compared with 48% of the other men enrolled (χ^2 = 2.29; df = 1; NS). Sixty-seven percent of the missing group were beer and/or spirit drinkers compared with 48% of the rest of the enrolment cohort (χ^2 = 1.07; df = 1; NS).

The trend thus was for the missing men to be younger, not so severely addicted to alcohol and more likely to be employed, but only the data on longest unemployment reaches statistical significance.

Results

The project team were able to assist only the men who came in for detoxification. Although the probands were all urged to attend the out-patient clinic for the project team to determine what help they needed or wanted, and specific appointments were made with most of them, few men kept the appointments. None of those who did not later come in for detoxification came for assistance in other respects. Thirteen of the probands were never admitted for detoxification, so that the project team never had a chance to assist one quarter of the probands during the year which was available to them for special help.

It usually took several admissions for detoxification for the project team to get to know the men well enough to try to assess their needs and the possibility of their benefiting from further treatment and attempts at rehabilitation, for the men to know and trust the team, and

for them to begin to feel that there might be a chance of living a different kind of life. Hardly any of the alcoholics were happy with their existence, but most of them had felt resigned to it and could see no way out.

The project team did not expect to make any dramatic changes in the life-style or the drinking behaviour of the proband group. Twelve months is little time in which to alter a lifetime pattern, and the resources available were meagre for such a task. However, there were a few changes for the better in the proband group which were encouraging.

Obviously it was unrealistic to expect sudden total abstinence from many, or indeed any, of the men. The follow-up questionnaire asked for details of the drinking habits of the men, the longest time they were abstinent between drinking bouts, the amount of alcohol they were drinking and the type of drink taken, to see if there had been any change. Data from the follow-up questionnaire was compared with that from the enrolment questionnaire to assess whether or not there had been any increase in social stability, measuring this by marital status, accommodation situation and employment record.

Drinking habits

There was no gross difference between the duration of abstinence in the proband group in the year before enrolment and the year after enrolment. Nor was there any difference between the proband group and the control group (Table 9.12).

Table 9.12

LONGEST ABSTINENCE

Year before enrolment

	Probands (N = 52) %	Controls (N = 48) %
1 day - 6 days	53	44
1 < 4 weeks	19	27
1 < 3 months	11	19
3-6 months	10	6
over 6 months	6	0

NS

Year after enrolment

	Probands (N = 52) %	Controls (N = 48) %
1 day - 6 days	49	39
1 < 4 weeks	22	25
1 < 3 months	7	17
3-6 months	14	12
over 6 months	5	3

NS

It seems likely that there may be inaccuracy in the answers to this question given by the control group both for the year before and the year of the study and by the proband group for the year before the study. It is possible that the men might tend to exaggerate the time of sobriety. However the proband group would have known at follow-up that the interviewers were quite familiar with their drinking habits and had records to check their statements. This might lead to the proband group's length of abstinence

during the year of enrolment appearing relatively lower than it might have done otherwise.

Comparison of the answers given by the individual men to the question about longest abstinence on the enrolment questionnaire and on the evaluation questionnaire, shows that over half of the men (55%) gave the same length of time for both the year before enrolment and the year after enrolment. This group of men was composed of 23 probands and 20 controls. Eighteen men (10 probands and eight controls), gave longer times of abstinence for the year after enrolment than for the year before enrolment. A change for the worse was indicated by eight probands and five controls in that they said they had been abstinent for shorter times during the year after enrolment than during the year before enrolment. However, the 18 who improved showed longer increase in sobriety, mainly from three to six months (with one proband over nine months), than those who showed a decline, the period falling by only a fortnight or up to three months.

Table 9.13

AMOUNT OF DRINK CONSUMED

Year after enrolment

	Probands (N = 42) %		Controls (N = 36) %	
much more	5	19	8	16
more	14		8	
the same		31		39
less	31	50	19	44
much less	17		22	
none	2		3	

NS

Table 9.13 shows the amount of drink reportedly consumed by the two groups during the year of the study, compared with former amounts, also is essentially the same for the proband group and the control group.

An interesting aspect of this data is that both the probands and the controls were improving. A few of the controls were receiving help from other sources. But from interviewing most of them the project team formed the impression that they were improving for other reasons. Several authors have commented on spontaneous remission in alcoholics after the age of 40 (Drew, 1968; Kendell and Staton, 1966), and Emrick (1975), in a review of 384 studies of treatment outcome, found that many alcoholics diminish or stop their drinking with no or minimal treatment. Drew excluded alcoholic offenders from his observations, but it seems likely that the tapering off of drinking he refers

to may apply at least to some alcoholic offenders as well. The project cohort described some factors which would seem to contribute to this result. The men over 40 or 50 commented on the increasingly adverse effect of drink on their health. Their tolerance was markedly worse than it had been when they were younger. And, perhaps most important of all, they could no longer find work. A large number of them had no work skills and had been employed as general labourers. After 45 or 50, they no longer had the physical strength required for that sort of job. As a result, their incomes dropped and they could afford comparatively little alcohol.

Table 9.14

TYPE OF ALCOHOL CONSUMED

Year before enrolment

	Probands (N = 52)		Controls (N = 48)	
	N	%	N	%
Beer/spirits	19	37	33	68
Wine/crude spirits	33	63	15	32

$\chi^2 = 9.12$; df = 1; $p<0.01$

Year after enrolment

	Probands (N = 42)		Controls (N = 36)	
	N	%	N	%
Beer/spirits	13	31	22	61
Wine/crude spirits	28	67	11	39
(Not known)	(1)	(2)		

$\chi^2 = 7.62$; df = 1; $p<0.01$

Table 9.14 shows that the probands continued to be drinkers of wine and/or crude spirits more than the controls in about the same proportion as when they were enrolled. There does not therefore appear to be any change in the type of alcohol consumed, though this data must be examined in conjunction with the amount of alcohol consumed, frequency of drunkenness and periods of abstinence.

The consistency of the men's replies to these questions on their drinking habits which they were asked on two occasions at least a year apart would indicate that there was high reliability and validity in the figures.

Marital status

There were three changes in marital status during the enrolment year. One of the probands who had been cohabiting for several years with a woman who was also an alcoholic, was sober long enough to fill in the necessary forms and to organise a wedding. Shortly after a control was enrolled his wife left him. Another of the controls went back to living with his wife after having been separated. During the year, another agency had been helping him and he became abstinent.

Accommodation

The tables concerning accommodation show some improvement for the probands during the year: the number

of men who were living in common lodging houses or night shelters was lower among the probands at the end of their year, while the controls remained about the same (Table 9.15).

Table 9.15

ACCOMMODATION : TYPE OF PREMISES

Year before enrolment

	Probands (N = 52) %	Controls (N = 48) %
Living in common lodging house or night shelter	56	40
Living in owner-occupied house, rented house, corporation house, digs, hostel, hospital or prison	45	60
	NS	

Year after enrolment

	Probands (N = 42) %	Controls (N = 36) %
Living in common lodging house or night shelter	29	47
Living in owner-occupied house, rented house, corporation house, digs, hostel, hospital or prison	71	53
	NS	

Comparing individual replies, it was found that over half of the men (20 probands and 24 controls) stayed in the same type of accommodation during the year. Twenty men (16 probands and four controls), improved the quality of

their accommodation. The probands did significantly better than the controls, as seen in Table 9.16.

Table 9.16

CHANGE IN ACCOMMODATION
during year of enrolment

Type of premises

	Probands (N = 42) %	Controls (N = 36) %
Improved	38	11
Same	48	67
Worse	14	22

$\chi^2 = 10.2$; df = 2; $p < 0.01$

The 16 probands who improved include seven who moved from a common lodging house or night shelter into hospital or hostel as a step in the project team's efforts at rehabilitation. Excluding these seven men, however, the probands still improved their accommodation compared with the controls; 21% of the other probands were living in a better home after one year on the project compared with 11% of the controls. There were 14 men (six probands and eight controls), whose accommodation worsened. This seemed to be due to their usual pattern of moving between common lodging house, prison, hospital and sleeping rough rather than to any other factors.

More probands were living with others, instead of alone, after the year of enrolment, while the controls had not changed significantly (Table 9.17).

Table 9.17

ACCOMMODATION : PERSONS LIVED WITH

Year before enrolment

	Probands (N = 52) %	Controls (N = 48) %
Lived alone	73	65
Lived with others	28	35

NS

Year after enrolment

	Probands (N = 42) %	Controls (N = 36) %
Lived alone	38	69
Lived with others	62	32

$\chi^2 = 6.43$; df = 1; $p < 0.02$

Comparing the questionnaires of individuals, the project team found that 54 men (28 probands and 26 controls) remained living with the same companions as they had been when enrolled (21 men), or remained living alone (33 men). However, 15 men (13 probands and only two controls) improved their situation in that they no longer lived alone as they had done when enrolled. During the year, nine men (one proband and eight controls) lost the companions they had had on enrolment. The eight controls were leading solitary lives; the one proband had substituted a cohabitee for the wife who left him.

Table 9.18 shows that significantly more probands had improved the quality of their living situation in respect of their being less isolated.

Table 9.18

CHANGE IN ACCOMMODATION

during year of enrolment

Number of persons lived with

	Probands (N = 42) %	Controls (N = 36) %
More	13	2
Same	29	26
Fewer	0	8

$\chi^2 = 15.9$; df = 2; $p < 0.001$

Employment

Table 9.19 gives the answers to questions in the evaluation questionnaire concerning employment.

Table 9.19

EMPLOYMENT

Year before enrolment

	Probands (N = 52) %	Controls (N = 48) %
Men who have worked during the year	42	42
Unemployed during year	58	58

Year after enrolment

	Probands (N = 42) %	Controls (N = 36) %
Men who have worked during year	52	47
Unemployed during year	48	53

No significant difference was found in the probands (or controls) overall as far as employment was concerned, although individual probands were known by the project team to have worked more during the year than they had done for several years.

Comparison of individual questionnaires showed that only four men were employed full-time both on enrolment and on evaluation, one proband and three controls. Thirty-five men (19 probands and 16 controls), including seven who were retired, remained unemployed during the experimental year. Eight men worked a part year for about the same length of time in each of the two years. There had been an improvement in the length of time worked for 18 men, and a decline in the length of time worked for 13 men. There was no significant difference between the proband and the controls in any of these categories.

At enrolment all subjects gave their permission for the project team to examine their penal, hospital and employment records and they were assured that all information would be treated with the strictest confidentiality.

In order to verify the statements relating to employment made by the cohort, and to obtain any additional information, the project team contacted the local officers of the Employment Service Agency which keeps records of employment and of unemployment for those looking for work

and claiming benefits. It had been thought that this body, which replaced the corresponding part of the Department of Employment, would keep records of all periods out of work, and hence time in work could be deduced. The personnel were most helpful, but the results were disappointing. Unfortunately, the records available produced hardly any information from which to conclude either that the men concerned were working or that they were not working.

The agency had records for 48 of the 100 men in the cohort (25 probands and 23 controls). However, these records were incomplete. In only three cases were as much as a year of either employment or unemployment recorded for a man; the rest of the records accounting for only a few months out of a year. The employment records of 34 men were essentially the same as that given by the men themselves. In three other cases, the records indicated that the men had been employed when they had said they had been unemployed. Six men said they were employed when the agency had no record of it. Six further men had records for one year which matched with what they said and records for the other year which did not match. The records supplied by the agency included three retired men.

The replies given about employment by the remaining 52 men in the cohort showed that 24 of the men said that they had been unemployed, including four who were retired, and 28 said that they had been employed for at least part

of the two years in question. Apparently whether a man has been employed or unemployed is not significant in determining whether or not he has a record with the Agency.

In summary the data on employment is not helpful one way or the other. It does not seem from the men's replies that the probands were working more; but those most likely to have a better work record are those having completed a course of rehabilitation. In psychiatric hospitals and Thornybauk Hostel patients and residents do not initially go to work and thus much change would not be expected.

Quality of life

Some of the probands commented that 'things were going better' for them. The data from the evaluation questionnaire (Table 9.20) shows how many men felt that their life was better, or worse, during the year of enrolment.

Table 9.20

QUALITY OF LIFE

During year after enrolment

	Probands (N = 42) %	Controls (N = 36) %
Better	52	28
the Same	17	42
Worse	26	25
Other	0	6
(Not known)	(5)	(0)

$\chi^2 = 11.2$; df = 2; $p < 0.01$

Considerably more of the probands felt that life was better for them during that year than controls. It is difficult to convey how the subjects viewed their year in the project other than by anecdotes. One of the probands wrote from prison on Christmas day near the end of his year since enrolment. He had received a six-month sentence for stealing £80 (to buy drink) from the hotel where he was working as a night porter:

> "Well, Mrs. Griffith, now that it is over, all I can do is try again. I can't say that last year was exactly a triumph over the 'auld enemy', but in some ways it was quite successful for me. At least I had four jobs in a year and that was after fifteen years of unemployment. So I suppose you could say that being a patient under yourself and Dr. Hamilton must have influenced me in some way .... I think this contact gave me an incentive to try harder (not always successfully, alas), knowing I suppose that at least someone cared for your welfare and tried to understand your problems and have found myself with a sense of direction again after being nearly rudderless for so long."

AT SIX MONTHS AFTER COMPLETION OF EXPERIMENTAL YEAR

After the completion of a year since enrolment by each proband and control subject, data from court and prison records was again studied to determine the subjects' penal records in the six months following the experimental year. Two further probands were excluded as they died in that six month period. Again each individual was given a score on each of the variables measured, and this was compared with the corresponding score for the first six months of the year before enrolment. The difference between scores was again subjected to Student's 't' test to find the significance of variation from zero for the probands in each of the periods studied, and the same for the controls. 't' was then calculated to find the significance of the difference between probands and controls.

Table 9.21

NUMBER OF COURT APPEARANCES

a) for 'Drunk and Incapable'

	In the first 6 months of the year before enrolment	In the 6 months following year of enrolment	% change	
Probands: N = 45 per 100 probands	77 171	77 171	0	t = 0 df = 44 NS
Controls: N = 44 per 100 controls	39 89	90 205	+ 156%	t = 1.9900 df = 43 NS

t = 1.6812; df = 87; NS

b) for All Drunkenness Offences

	In the first 6 months of the year before enrolment	In the 6 months following year of enrolment	% change	
Probands: N = 45 per 100 probands	94 209	99 221	+ 5%	t = 0.2762 df = 44 NS
Controls: N = 44 per 100 controls	53 120	119 270	+ 124%	t = 2.0730 df = 43 p<0.05

t = 1.6873; df = 87; NS

c) for All Offences

	In the first 6 months of the year before enrolment	In the 6 months following year of enrolment	% change	
Probands: N = 45 per 100 probands	118 262	109 242	- 8%	t = 0.4778 df = 44 NS
Controls: N = 44 per 100 controls	70 159	131 298	+ 87%	t = 1.8787 df = 43 NS

t = 1.8803; df = 87; NS

Table 9.22

NUMBER OF DAYS IN PRISON

a) for 'Drunk and Incapable'

	In the first 6 months of the year before enrolment	In the 6 months following year of enrolment	% change	
Probands: N = 45 per 100 probands	336 747	247 549	- 26%	t = 0.8096 df = 44 NS
Controls: N = 44 per 100 controls	60 136	216 477	+ 260%	t = 2.0839 df = 43 p< 0.05

t = 0.5245; df = 87; NS

b) for All Drunkenness Offences

	In the first 6 months of the year before enrolment	In the 6 months following year of enrolment	% change	
Probands: N = 45 per 100 probands	571 1269	380 844	- 34%	t = 1.2169 df = 44 NS
Controls: N = 44 per 100 controls	223 507	473 1075	+ 112%	t = 1.5742 df = 43 NS

t = 1.9781; df = 87; NS

c) for All Offences

	In the first 6 months of the year before enrolment	In the 6 months following year of enrolment	% change	
Probands: N = 45 per 100 probands	983 2184	715 1589	- 27%	t = 1.1170 df = 44 NS
Controls: N = 44 per 100 controls	600 1364	663 1507	+ 10%	t = 0.3744 df = 43 NS

t = 1.1216; df = 87; NS

Table 9.23

NUMBER OF TIMES IN PRISON

a) for 'Drunk and Incapable'

	In the first 6 months of the year before enrolment	In the 6 months following year of enrolment	% change	
Probands: N = 45 per 100 probands	36 80	34 76	- 6%	t = 0.1721 df = 44 NS
Controls: N = 44 per 100 controls	8 18	33 75	+ 312%	t = 2.1951 df = 43 p<0.05

t = 1.6754; df = 87; NS

b) for All Drunkenness Offences

	In the first 6 months of the year before enrolment	In the 6 months following year of enrolment	% change	
Probands: N = 45 per 100 probands	46 102	48 107	+ 4%	t = 0.1573 df = 44 NS
Controls: N = 44 per 100 controls	19 43	54 123	+ 184%	t = 2.1171 df = 43 p<0.05

t = 1.6026; df = 87; NS

c) for All Offences

	In the first 6 months of the year before enrolment	In the 6 months following year of enrolment	% change	
Probands: N = 45 per 100 probands	58 129	54 120	- 7%	t = 0.4263 df = 44 NS
Controls: N = 44 per 100 controls	29 66	60 136	+ 107%	t = 1.8549 df = 43 NS

t = 1.6854; df = 87; NS

Table 9.24

SUMMARY OF DEGREES OF STATISTICAL SIGNIFICANCE OF TABLES 9.21 TO 9.23

	Significance from zero p<		Probands v. Controls
	Probands	Controls	
Court Appearances:			
Drunk and Incapable	NS	NS	NS
All Drunkenness Offences	NS	0.05	NS
All Offences	NS	NS	NS
Number of days in prison:			
Drunk and Incapable	NS	0.05	NS
All Drunkenness Offences	NS	NS	NS
All Offences	NS	NS	NS
Times in prison:			
Drunk and Incapable	NS	0.05	NS
All Drunkenness Offences	NS	0.05	NS
All Offences	NS	NS	NS

It is recognised that the methods of collection of data are both retrospective and prospective but with the negative results obtained this criticism can be largely discarded. The results show that there was no difference in the court and prison records for the probands or controls in the pre and post-experimental periods. It can otherwise be stated that the null hypothesis - that the detoxification service had no lasting effect on the probands' convictions for drunkenness - cannot be discarded. It is seen in Tables 9.21 to 9.23 that the control subjects have worse penal records in the second period, reaching the 5% level of significance on four variables; comparison of probands and controls does not however reach statistical significance.

The period of the first six months in the year before enrolment was chosen for comparison with the six months following the experimental year as these periods represented the same calendar months for each individual, and also as the period of the six months immediately prior to enrolment would often contain a court appearance (and perhaps a prison sentence) by virtue of the methodology of enrolment. It was considered however that it would be useful to examine the penal data for the six months immediately prior to the experimental year with the six months immediately following the experimental year (Tables 9.25, 9.26).

Table 9.25

NUMBER OF COURT APPEARANCES
for 'Drunk and Incapable'

	In the 6 months before enrolment	In the 6 months following year of enrolment	% change	
Probands: N = 45	109	77	- 29%	t = 1.7391 df = 44 NS
per 100 probands	242	171		
Controls: N = 44	68	90	+ 32%	t = 1.0067 df = 43 NS
per 100 controls	154	205		

t = 1.8859; df = 87; NS

For 'All Drunkenness Offences' there was a similar fall of 29% in the conviction rate among the probands and a rise of 18% in the control group. For 'All Offences' the fall in the probands was 26% and the rise in the controls 16%. As in Table 9.25 in none of these measures were the percentage

changes statistically significant between the two periods studied, nor when the probands were compared with the controls.

The data on 'Times in Prison' showed falls of 26%, 23% and 23% among the probands, and rises of 73%, 32% and 22% among the controls for the different groupings of offences. Again none of these changes was statistically significant.

The number of days in prison for 'Drunk and Incapable' and for 'All Drunkenness Offences' fell by 38% and 43% respectively for the probands, and for the controls the corresponding figures were a rise of 8% and a fall of 2%. These changes were not statistically significant.

Table 9.26

NUMBER OF DAYS IN PRISON

for All Offences

	In the 6 months before enrolment	In the 6 months following year of enrolment	% change	
Probands: N = 45 per 100 probands	1117 2482	715 1589	- 36%	t = 2.3428 df = 44 p<0.02
Controls: N = 44 per 100 controls	822 1868	663 1507	- 19%	t = 0.7658 df = 43 NS

t = 0.8788; df = 87; NS

Table 9.26 shows that the probands had a fall in the number of days in prison between the two periods, significant at

$p<0.02$ but this was not significant when compared with the control group.

In summary then the data from these two six month periods is not statistically significant but it is seen that in each measure the probands have improved, with 29% less convictions for drunkenness offences, whilst the convictions for the controls have increased by 32%. In the short period of one year's eligibility for provision of therapeutic care for each proband (with 25% of them never coming to the detoxification centre) it is encouraging that there is a definite trend towards improvement. It seems reasonable to hope that with a longer period of providing the service the results might have reached statistical significance.

SUMMARY

As stated on page 68 one of the aims of the project was to evaluate the effectiveness of this detoxification and assessment service for alcoholic offenders. Although the design of the project involved agreement by the police not to prosecute proband subjects for drunkenness offences, it was not known to what degree co-operation could be maintained between the police, the patients and the hospitals concerned. The co-operation of the hospital staff is discussed in Chapters 6 and 7, and as already stated (pages 147 and 148), two patients were removed from the proband group because of gross lack of co-operation.

The co-operation of the police and prosecuting authorities was excellent as is shown in Table 9.1 in that the court appearances for 'Drunk and Incapable' among the proband group fell by 89% and there were easily understandable reasons for the 20 prosecutions which did take place in the experimental period. Table 9.2 shows that the police exercised their discretion for 'Other Drunkenness Offences'. As stated on page 193 there was an overall saving, on the data obtained on 47 probands in the course of 12 months, of 180 court appearances, 87 receptions into prison and 1,112 days in prison.

The effectiveness of the project as an assessment and referral service is shown in Tables 9.4e and 9.6c. The number of successful referrals to and days spent in institutions providing care and rehabilitation were increased in the proband group to a very highly significant extent.

From the total number of days spent by each subject in hospitals, hostels and prison, it can be seen that the number of days when the subjects were not at liberty to drink has greatly increased. Data from the combined court appearances for drunkenness offences and admissions for detoxification show that the probands were not, so far as can be known, becoming drunk any more often than before. There is no evidence to show that proband subjects saw the project as a 'licence to get drunk'. This is a criticism which has been applied to the project and it is therefore

important to note all instances in which the probands did not do 'worse' than the controls: in none of our measures was this the case.

More data on the effectiveness of the project on the subjects' drinking behaviour was obtained from the follow-up questionnaire which showed that the periods of longest duration of abstinence were not shorter among the probands (or the controls) in the year after enrolment compared with the previous year. As discussed on page 214, there is reason to believe that some probands (and controls) had markedly improved. It was also seen in Table 9.13 that 50% of the probands (and 44% of the controls) reported drinking less, much less or no alcohol in the year after enrolment.

The effectiveness of the project on the social stability of the subjects can be discussed in relation to marital status, employment and accommodation. In Chapter 4 it was seen that the mean age of the cohort was 49; 55% of the cohort were single, 30% showed breakdown of marriage and 5% were widowed. It is not surprising that there were only minimum changes in marital status.

It was encouraging that significantly fewer probands were living in a night shelter or common lodging house, that 38% of the probands improved their quality of accommodation (significantly more than the controls) and that significantly fewer probands were living alone compared with the year before enrolment.

It is disappointing that not more data was available on employment but again not much improvement could be expected in a group of men of that age, 72% of whom were unemployed on enrolment and for the reason previously stated, namely that to some extent a course of treatment involves the subject not working.

The subjective impression of the probands themselves was that the quality of their lives had improved in their experimental year, and their scores in reply to this question compared with the controls were very highly significant.

The time limit of the project did not permit further questionnaire evaluation of the subjects in the period following the year since enrolment. It was only possible to study penal data for the six months following the end of the experimental year and when this data was compared with the six months prior to enrolment it was seen that court appearances for drunkenness offences had fallen by 29% among the probands. Whilst this did not reach statistical significance in comparison with the controls, there was a definite trend, including the data on times in and days in prison, for the probands to have improved. It is suggested that had there been more aftercare facilities available, these results would have been more satisfactory.

It is unrealistic to expect much 'carry-over' effects after the provision of the service has ceased in a group of socially-deteriorated alcoholics and proper evaluation

should more properly be carried out in a service that has a longer life and in an area providing more facilities for rehabilitation. Our results suggest that the results that could then be expected might be even more satisfactory.

CHAPTER 10

SURVEY OF RANDOM DRUNKEN OFFENDERS

SURVEY OF RANDOM DRUNKEN OFFENDERS

As noted in Chapter 2, the Criminal Justice Act (1967), section 91, removes the penalty of imprisonment for drunken offenders, but will not be implemented until there is 'suitable accommodation for the care and treatment of (those) drunk and disorderly'. It is envisaged that the first detoxification centres in Britain will be concerned with catering for 'police' cases (rather than 'open door' units), that is any public drunkard apprehended by the police.

The enrolment criteria for subjects in the habitual drunken offender cohort (hereafter referred to as HDO) required the subjects to be male, habitual offenders and alcoholics. Not all drunken offenders meet these criteria and in order to compare the project subjects with random drunken offenders with a view to obtaining a better picture of likely candidates for a detoxification unit, the project team interviewed 50 men and women presenting at the Edinburgh Burgh Court after being convicted of a drunkenness offence. These random drunken offenders are hereafter referred to as 'RDO'. The questionnaire used is given in Appendix K and definitions in Appendix L.

A drunkenness offence included being 'drunk and incapable' (78%), having committed a breach of the peace whilst drunk (20%), or another petty offence whilst drunk

(2%). The subjects were randomly selected for interview on each day the court sat in the five weeks from 8th April 1975. Two individuals refused to be interviewed, one 'didn't have time' and the other found the questions 'too personal'. Individuals who had been included in the HDO group were excluded. For statistical reasons it was advisable not to have the same individuals in both 'RDO' and 'HDO' groups, as this would complicate comparisons between the groups. Further we knew that a larger survey of random offenders in the same court had been undertaken (by R. Flint) and is awaiting publication.

There were no differences between the HDO and RDO groups unless otherwise stated.

SEX

There were 41 men and nine women in the RDO cohort.

AGE

The range, mean and standard deviations of the cohort are given in Table 10.1:

Table 10.1

AGE

	Women (N = 9)	Men (N = 41)	Total (N = 50)
Range	33-71	17-75	17-75
Mean	50.0	44.4	45.4
SD	10.6	16.6	15.6

NATIONALITY

The place of birth of the RDO group did not differ from the Edinburgh population and did not have an over-representation of Irish as did the HDO group.

MARITAL STATUS

As in the HDO group, in the RDO group those married were underrepresented and those single and divorced over-represented as compared with the Edinburgh population. Only eight men and two women were living with their spouses; 11 men (27%) and five women (56%) showed breakdown of marriage.

Table 10.2

MARITAL STATUS

	All (N = 50)		Males (N = 41)		Females (N = 9)	
	N	%	N	%	N	%
Single	18	36	17	41	1	11
Married	10	20	8	20	2	22
Cohabiting	1	2	1	2	0	0
Living apart	5	10	4	10	1	11
Separated	5	10	2	5	3	33
Divorced	6	12	5	12	1	11
Widowed	5	10	4	10	1	11

Table 10.3

LOCATION OF ACCOMMODATION

	Random Offenders (N = 50) %	Habitual Offenders (N = 100) %	Edinburgh Population (N = 453,584) %
Grassmarket/ Cowgate area	26	43	2.4
Craigmillar/ Niddrie area	14	4	5.4

Table 10.3 shows the overrepresentation of subjects from the Grassmarket/Cowgate area in both offender groups. The Craigmillar/Niddrie area of the city is a socially deprived area of mainly Corporation houses with a high incidence of parasuicide, vandalism, crime, etc. (Ebie, 1971). This area is overrepresented in the RDO group but not in the HDO group (General Register Office, 1973).

More of the RDO group (26%) than the HDO group (16%) lived in a Corporation house and less in a common lodging house or night shelter (RDO 32%, HDO 48%).

Forty-four percent of the RDO group could be classed as homeless on the basis of where they had usually lived in the past year. One elderly woman had spent most of the year travelling throughout Britain on railway trains without paying her fare, periodically being apprehended by the police and sent to jail. She said she had nowhere else to live and liked trains.

Fifty-four percent of the HDO group lived alone, 20% with their spouses and six (12%) with their parents.

SOCIAL CLASS AND EMPLOYMENT

The social class of the RDO group paralleled that of the HDO's differing from the Edinburgh population by being underrepresented in the higher social classes I, II and III (offenders 36%, Edinburgh population 75%) and overrepresented in the group of unskilled labourers (offenders 46%, Edinburgh population 9%).

The social class of the RDO's fathers did not differ from the Edinburgh population.

Twenty-three (46%) of the cohort were unemployed, 34% in full-time employment, the others housewives or retired. Only 12 individuals (24%) had been in work continuously in the last 12 months.

DRINKING HISTORY

The replies of the individuals to questions concerning their drinking habits were:

a) People have different feelings about the amount they would like to drink. Which of these statements comes closest to the way you feel?

	Total (N = 50) N	%
Wish could drink more	0	0
Satisfied with amount	15	30
Feel should drink less	4	8
Definitely like cut down	24	48
Other	7	14

b) Have you ever tried to cut down your drinking?

Yes	36	72
No	14	28

c) Were you ever a heavier drinker than you are now?

No	31	62
Slightly	3	6
Much	14	28
Not sure	2	4

d) Have you ever had difficulties at work because of drinking?

No	28	56
Yes	17	34
Other	1	2
(not known)	(4)	(8)

e) Has your doctor ever advised you not to drink as much as you do?

No	27	54
Yes	19	38
(not known)	(4)	(8)

f) Have you ever had trouble or quarrels with family or friends because of your drinking?

No	25	50
Yes	22	44
(not known)	(3)	(6)

g) Have you ever had financial problems because of your drinking?

No	27	54
Yes	19	38
Other	1	2
(not known)	(3)	(6)

h) Have you ever gone without a drink for a period to prove you can do so?

	Total (N = 50) N	%
No	16	32
Yes	32	64
(not known)	(2)	(4)

i) Do you ever find when you start drinking you can't stop?

No	21	42
Yes	25	50
Other	1	2
(not known)	(3)	(6)

j) During the last 12 months how often have you had a drink?

Every day	13	26
Most days	11	22
Weekends or 1-2 times a week	22	44
1-2 times per month	1	2
1-2 times every 6 months	1	2
1-2 times a year	1	2
(not known)	(1)	(2)

Comparing these figures with those obtained in the study by Edwards et al (1972) of drinking habits of a sample of adults in the general population in London, it is seen from Table 10.4 that more of the random Edinburgh offenders drink regularly.

Table 10.4

FREQUENCY OF DRINKING

Frequency of drinking	London males (N = 408) %	London females (N = 520) %	Edinburgh offenders (N = 50) %
Every day	11	4	26
Most days	11	4	22
Less often	78	92	50

Subjects were also asked for the longest period of unenforced abstinence in the 12 months prior to interview:

Table 10.5

LONGEST ABSTINENCE in last year

	Random Offenders (N = 50) %	Habitual Offenders (N = 100) %
Less than 1 day	8	14
1 day - 1 week	16	35
1 week - 1 month	34	23
1-6 months	26	23
6-12 months	12	3
(not known)	(4)	(2)

$\chi^2 = 11.4$; df = 4; $p < 0.025$

It is seen that more of the RDO group reported longer periods of abstinence than the HDO group.

TYPE OF ALCOHOL TAKEN

Table 10.6

TYPE OF ALCOHOL TAKEN

	(N = 50) N	%
Beer only	18	36
Spirits only	6	12
Wine only	3	6
Beer and spirits	9	18
Wine and crude spirits	4	8
Other	10	20

The RDO group were mainly beer and spirit drinkers. They did not differ from the control group of the HDO

cohort but were less likely to be wine drinkers than the probands in the HDO group ($\chi^2 = 17.6$; df = 1; $p < 0.001$).

SYMPTOMS OF ALCOHOL ADDICTION

Table 10.7

ALCOHOLISM SYMPTOMS

	(N = 50) Number 'Never'	Number 'Yes'	(Number not known)
Amnesias	14	35	(1)
Morning shakes	21	28	(1)
Fall in tolerance	20	27	(3)
Morning drinking	22	27	(1)
Delirium tremens	37	12	(1)
Withdrawal fits	33	6	(11)

Table 10.8

FREQUENCY OF ALCOHOLISM SYMPTOMS

Number of symptoms	Number of individuals
0	8
1	9
2	4
3	9
4	12
5	6
6	2

It can be seen from Tables 10.7 and 10.8 that two-thirds of the cohort had two or more symptoms of physical dependence on alcohol.

PROCESS OF ALCOHOLISM

The ages at which individuals first bought or were bought an alcoholic drink are given in Table 10.9.

Table 10.9

AGE FIRST TOOK A DRINK

Years	(N = 50) N	%
14 or less	6	12
15, 16, 17	18	36
18	5	10
19-25	17	34
26 and over	3	6
(not known)	(1)	(2)

These distributions did not differ from the HDO cohort. (See Chapter 4 for comparison with general population.)

Table 10.10

PROCESS OF ALCOHOLISM

Number of years since	Never %	1-10 years %	10+ years %	(not known) %
First got drunk	0	14	80	(6)
First drinking most days	28	16	50	(6)
First arrested for drunkenness	0	52	46	(2)
Drink started interfering with life	38	20	38	(4)
First in prison for drunkenness	48	16	32	(4)
First lost a job through drink	62	20	16	(2)

From Table 10.10 it is seen that 72% of the RDO group drank on four or more days of the week, 62% consider drink interfered with their lives, 38% had lost a job through drink and 52% had been in prison for a drunkenness offence. The HDO group scored higher than the RDO's in all these categories but in the RDO group the pattern of events parallels that of the HDO group.

PHYSICAL COMPLICATIONS

Thirty-five percent of the cohort had symptoms of gastritis or peptic ulcer. Thirty-four percent had been physically assaulted at least once (half as many as in the HDO group) and 25% had been involved in traffic accidents (compared with 40% in the HDO group).

ABUSE OF DRUGS

Twenty-two percent of the RDO group had abused drugs not prescribed for them, including 10% in the last year.

PSYCHIATRIC TREATMENT

Thirteen individuals had had in-patient psychiatric treatment, they said other than for alcoholism. Nineteen had attempted suicide in the past, 15 of whom were admitted to hospital. Fourteen had had previous treatment for alcoholism including eight from a psychiatrist and five from another doctor, usually their general practitioner.

SELF PERCEPTION OF BEING AN ALCOHOLIC

Sixty-two percent denied they were alcoholic, 32% accepted they were, 6% answered otherwise. The figure of one-third recognising they were alcoholic is identical to that found by Hershon et al (1974) in their study of 132 random drunken offenders in a London court.

Table 10.11

ARE YOU AN ALCOHOLIC?

	Habitual Offenders (N = 100) %	Random Offenders (N = 50) %
No	34	62
Yes	62	32

$\chi^2 = 10.7$; df = 1; $p < 0.01$

From Table 10.11 it is seen that the RDO group were less likely than the HDO group to see themselves as alcoholics.

SPONTANEOUSLY COMPLAINED OF PROBLEMS

Hershon et al (op.cit.) asked their offenders if they had any problems. We attempted to replicate this and asked the same question noting the answers given without prompting or probing. The findings are compared in Table 10.12.

Table 10.12

RELATIVE FREQUENCY OF PROBLEMS

	London study (N = 132) %	Edinburgh study (N = 50) %
Domicile	14	24
Drinking	29	20
Work	5	22
Money	4	16
Inter-personal	6	14
Physical ailments	17	8
'Nerves'	11	6
Clothes	2	6
Other	0	4

Table 10.13

NUMBER OF PROBLEMS COMPLAINED OF

Number of problems	Edinburgh offenders (N = 50) %
0	42
1	26
2	14
3	10
4	2
5	2
8	2
(not known)	(2)

Possible differences in coding practice make the studies difficult to compare but from Table 10.13 it is seen that 56% in the present study had at least one complaint and this compares with 52% in the London study.

The random offenders were asked:

"Why were you drinking yesterday?" (or day arrested)

The answers are recorded as some guide to the reasons for public drunkenness:

1 "drink every day"

2 "celebrating birthday"

3 "met a couple of friends I knew"

4 "can't remember"

5 "drinking with father; no special reason"

6 "with friends; drinking whisky usually drink beer"

7 "party"

8 "drink every day"

9 "just a wee daft sort of notion I had"

10 "just one of these things - I'm finished drinking now"

11 "I'm a chronic alcoholic"

12 "yes" (sic)

13 "met an old friend and drinking spirits"

14 "always drink, bad luck was picked up"

15 "no particular reason"

16 "don't know"

17 "met friends - took me out for a drink"

18 "drink all the time"

19 "had taken tablets along with drink - certain it was not the drink"

20 "just went out for a drink"

21 "always do"

22 no answer

23 "because I met friends"

24 "going for an injection"

25 "stag party (took pills as well, don't know what)"

26 "depressed, heavy cold. Met people who gave me drink but no food"

27 "at football match"

28 "no special reason"

29 "finished particular contract work"

30 "drink every day"

31 "was not drunk - trying to help drunken woman"

32 "just felt like a drink"

33 "just went for a drink and had too much"

34 "lost my pension book"

35 no answer

36 "landlady went away - all right when she's there"

37 "personal problems"

38 "same as usual - maybe a bit more whisky"

39 "drink every day"

40 "had just collected holiday money"

41 "just heard ex-wife has remarried"

42 "met a friend, gave me whisky, not used to it"

43 "problems on my mind - try to ease tension"

44 "just heard I became a granny six months ago"

45 "my nerves"

46 "no special reason"

47 "depressed with work"

48 "just habit"

49 "depression"

50 "away for the day with friends at football match"

These answers from the 50 subjects can be roughly summarised in three groups:

(1) 8 who drank every day, 7 who replied "no special reason" and one individual who replied that he was an alcoholic.

(2) 7 who had "met friends" (4 individuals said they had been drinking whisky and were unaccustomed to it)

9 in a "party" group, who had been at a party or other celebration and including 2 who referred to a "football match"

(3) 6 individuals mentioned 'psychological' reasons - interpersonal problems, 'depression' or 'nerves'.

The others 'didn't know', 'couldn't remember' or gave an unclassifiable answer. (How is one to classify 'just a daft wee notion'?)

This summary is concerned only with the answers given by the respondents who naturally will often have more than one reason for drinking. However the answers fall approximately into three groups of equal numbers which can be described as (1) regular drinkers, (2) sporadic drinkers, (3) others.

Subjects were asked if they wanted help with their drinking problem and the answers are given in Table 10.14.

Table 10.14

HELP WANTED WITH DRINKING?

	(N = 50) %
No problem	44
No help wanted	6
Yes	32
Getting help	2
Don't know	10
Other	6

Finally the offenders were asked whether, if they had had their choice, they would rather have been taken to hospital or spend the night in a police cell. Thirtyeight (76%) replied that they would prefer the hospital, 10 (20%) said that they preferred the police cell, and two didn't know.

CONVICTIONS FOR DRUNKENNESS

Table 10.15 shows the number of convictions for drunkenness offences of the RDO cohort:

Table 10.15

DRUNKENNESS CONVICTIONS

RDO cohort (N = 50)

No. of offences	In the last 12 months N	%	In lifetime N	%
0	0	0	0	0
1	24	48	10	20
2	5	10	6	12
3-5	14	28	5	10
6-10	2	4	10	20
11-25	2	4	8	16
26-50	3	6	3	6
51-100	0	0	3	6
101-200	0	0	3	6
201-300	0	0	0	0
over 300	0	0	1	2
(not known)	(0)	(0)	(1)	(2)

Thirty percent of the cohort had had no convictions for offences other than drunkenness, 34% had had 1-10 such convictions and 32% over ten. (These figures did not differ from those in the HDO cohort.)

Table 10.15 shows that 20% of the cohort were first offenders while two-thirds had had three or more lifetime convictions for drunkenness. Forty-two percent had had three or more convictions in the last year and would thus meet the criteria of the Habitual Drunken Offender Working Party (Home Office, 1971) for being a 'habitual drunken offender'.

Parr, in his (1962) study of drunkenness offences in London, found that in perusing the court records for variable period during 1957, 78% of the convictions were due to 'once-only' offenders. His study is sometimes misleadingly thought to say that only one in five offenders are 'habitual'; an analysis of his methods and results shows that this is not necessarily the case, his comments being limited to the records and period studied.

The present study showed 52% of the offenders had had more than one drunkenness conviction in the 12 months prior to interview, virtually the same (50%) as found by Gath in his (1969) study of male drunken offenders in London. Gath also found identical figures for those with over ten offences - 10%.

SUMMARY

The following are the most noteworthy of the findings in the random drunken offender survey:

1 60% were in social class IV or V
2 46% were unemployed
3 44% were homeless, 54% lived alone
4 32% showed breakdown of marriage
5 19% had attempted suicide
6 70% had had alcoholic amnesias
7 56% had had morning shakes
8 54% showed fall in tolerance
9 54% admitted to morning drinking
10 24% had experienced delirium tremens
11 16% had no symptoms of alcohol addiction

12 66% had two or more symptoms of alcohol addiction

13 32% accepted they were alcoholics

14 28% had had treatment for alcoholism

15 36% had lost their job through drink

16 58% said drink interfered with their lives

17 52% had had a previous arrest for drunkenness in the previous 12 months

18 66% had had three or more previous convictions for drunkenness in their lifetimes

19 48% had been in prison for a drunkenness offence

20 76% said they would rather have been taken to hospital than prison to dry out

In this group which excluded 11 habitual drunken offenders who were known to be alcoholics, 42% met the criteria for being a habitual drunken offender as defined by the Working Party on Habitual Drunken Offenders. Certainly a half, and more likely two-thirds, were alcoholics.

CHAPTER 11

DISCUSSION AND CONCLUSIONS

DISCUSSION AND CONCLUSIONS

Management of drunken offenders

Alcoholism is recognised as one of Britain's most serious medical and social problems today, and this is especially so in Scotland. In previous centuries attempts to control drunkenness through licensing and taxation have had varying success, but at present taxation seems to have little effect on consumption and Government Committees are recommending relaxation of the licensing laws. Attempts at the end of the last century to deal specifically with habitual drunken offenders by admitting them voluntarily or by compulsion to 'retreats' or 'reformatories' failed, and in Scotland in the year 1900 there was a rate of one conviction for drunkenness for every 50 of the population.

The number of offences declined until the end of the Second World War, but since then have been rising steadily. The increase is unlikely to be mainly due to increased law enforcement. In the last two decades the rate of convictions for drunkenness offences has doubled, with Scotland showing a greater acceleration than England and Wales. In 1974 there were about 50,000 convictions in Scotland and the number per head of population was about five times that in England and Wales. Further, in Scotland in 1973, drunkenness offences accounted for 23% of all receptions into prison.

Not all drunken offenders are alcoholics, but the study of random offenders in Edinburgh (Chapter 10) showed that probably two-thirds are, confirming Gath's (1969) findings in London. Current penal management has been shown not to prevent recidivism and 84% of the men sent to prison in Scotland for drunkenness in 1973 had had at least six previous convictions (Scottish Home and Health Department, 1974) and 40% more than 20 convictions. Ratcliff in 1966 in Scotland and Gath in 1969 in England demonstrated the ineffectiveness of court appearances and imprisonments as treatment measures. It seems unlikely that increased penalties would make penal measures more effective and there is no call for such action from the public or police. This is not to say that imprisonment is of no value whatsoever; clearly some police and magistrates, and indeed some offenders, see no alternative in the short term to prevent the individual further harming himself.

Detoxification centres

In some other countries, notably in Eastern Europe, Scandinavia and North America, non-penal management of drunken offenders has been tried and shown to be of value. In Eastern European countries the emphasis is more on short term medical management of public drunkenness in a 'sobering up' station, and no reports are available on their usefulness in treating alcoholism in individuals. The Swedish multidisciplinary approach appears comprehensive,

but there is a suspicion that many alcoholics do not come forward for treatment because of deep-seated fears of the Temperance Board. The Swedish labour camps for those not responding to rehabilitative measures are realistic and there is a similar facility in New York State (Griffith, 1973).

Pittman and Gordon in 1958 used the term 'revolving door' to describe the failure of repeated imprisonment to solve the problem of managing drunken offenders, and their work provided the stimulus to search for non-penal alternatives. In North America detoxification centres are seen as the first step in a continuous process of assessment, 'halfway houses' and long term rehabilitation. Despite the proliferation of detoxification centres throughout many States in the USA, very few controlled studies of their effectiveness have been published. The evaluation by Root (1970) was carried out only four months after patients' discharge from a detoxification centre, a point in time when the individuals will perhaps still be responding to the therapeutic endeavours initiated at the time of discharge, but not long enough to 'give them a chance to fail' to continue to respond to these measures. Moreover, the study was not controlled, and it will be seen in the present study that some of the control group improved with respect to drinking habits (Table 9.13), accommodation (Table 9.16), employment (text, page 222) and 'quality of life' (Table 9.20). Pittman and Tate's (1969) study did

not compare a group receiving treatment with one receiving no treatment, but rather evaluated the effectiveness of detoxification alone compared with detoxification plus further treatment for alcoholism. Statistical differences between their proband and control groups are given for very few measures and the only figure approaching statistical significance was improvement in employment rate ($p < 0.05$) before and after treatment, and that at three months following discharge. However, the before and after treatment comparisons in this and other studies have shown encouraging results and the study by Coffler and Hadley (1973), which will be referred to later, showed that alternatives to penal measures need not be more expensive.

In Britain it is only in the last few years that much consideration has been given to the establishment of detoxification centres. Hospitals, both psychiatric and general, DHSS reception centres, Salvation Army hostels, night shelters and church crypts have all been used more or less as detoxification centres. It was stated earlier (page 35) that many of those with the characteristics of the habitual drunken offender are either not treated by psychiatric hospitals and alcoholism treatment units, or, when they are, tend to have a poor outcome. Police lock-ups and prison cells provide the country's largest detoxification facilities, but, as noted earlier, their effectiveness in providing specific help for alcoholics is limited.

Parliament has passed legislation removing the penalty of imprisonment for drunken offenders in England and Wales, but this legislation will not be implemented until sufficient suitable accommodation is available, presumably the detoxification centres recommended in 1971 by the Home Office Working Party on Habitual Drunken Offenders.

Administration: implications for future detoxification centres

In Scotland prosecutions are initiated by the Procurator Fiscal, who, for the purposes of the present study, agreed to waive his right to prosecute the experimental subjects, and it is likely that future detoxification centres in Scotland will be able to function within the present law, provided that there is good understanding and close co-operation between administrators of such centres, police and Procurators Fiscal.

The Chief Constable in Edinburgh asked his police officers to escort 'card-carrying' drunks to the detoxification centre when found in circumstances which would otherwise result in their being charged with 'drunk and incapable', and to use their discretion when the drunkard was exhibiting disorderly or other antisocial behaviour. It was made clear to the police and Procurator Fiscal that the men concerned would be alcoholics with a history of previous drunkenness offences. The experimental subjects were also able to refer themselves for detoxification. Furthermore,

there were to be a limited number of 'card-carrying' subjects.

Clearly an 'open door' detoxification unit would attract other clientele. All alcoholics committing a drunkenness offence could be admitted via the police, or could refer themselves. Furthermore, those other than chronic alcoholics - 'spree', or 'payday' drinkers, or even those who become drunk in their own homes. Drunken drivers could be admitted by the police. The numbers involved can hardly be guessed and obviously the line would have to be drawn somewhere. A detoxification centre should aim to diagnose and refer for treatment those in the early stages of alcoholism, but to include all those abusing alcohol by becoming drunk would be quite impracticable. To start with, it seems appropriate to deal with those being found drunk and incapable by the police, and with those who have a history of previous convictions for drunkenness. The latter group could be identified by carrying a card which could be issued after a previous court appearance for drunkenness.

In the present project the police authorities anticipated problems in taking to a detoxification centre a drunkard who could not give his permission for them to do so; for that reason all subjects were enrolled when sober after the court appearance when they could intimate their willingness to participate in this scheme. None of those approached refused to take part, though two subjects

were later withdrawn from the proband group because they did not co-operate with the basic aims of the project. It was noted (page 254) that 76% of the group of random drunken offenders studied indicated they would have preferred to be taken to hospital for 'drying out', whilst 20% preferred police cells. As the latter group gave their answers the morning after spending a night in extremely austere surroundings, there certainly do seem to be some who would prefer to avoid a hospital detoxification centre.

A trial of an 'open door' policy in the present project was considered but rejected because of the numbers that might have been involved. With the beds available the group of 52 men was about right, and they were enrolled over the course of a year, thus all not being available for admission at the same time. With a restricted number of men it was thus possible to avoid excessive pressure on staff. On the other hand, some doctors, social workers and police, who had heard of the project and did not know of its limitations, were disappointed when the detoxification unit could not admit additional appropriate cases they had encountered.

Those drunken offenders being encountered by the police and appearing in Edinburgh Burgh (now District) Court each day in 1974 numbered an average of nine per day. The beds needed to cater for these would be the figure of nine multiplied by the length of stay in days. In other

words, a 'working size' ward of about 20 beds would probably suffice if the length of stay was 2-3 days. The mean length of stay overall in the present study was 3.2 days, but the median was two days, and less time might be necessary for those not so severely addicted to alcohol as those in this study. It might however be anticipated that more drunken offenders would be brought by the police to a detoxification centre than the numbers appearing in court (some at present are 'helped on their way' home by the police and might instead be 'helped' to the detoxification centre), but other offenders might refuse to go to hospital as noted earlier. Any calculation of likely bed needs in the future would also have to take account of the annual increase in the number of convictions for drunkenness.

Ethical considerations

The question of ethics in offering a new treatment to one group and not another was discussed and it was agreed that as the detoxification facility was of unknown benefit, objections could be discarded, the controls being in no way restricted in their use of existing facilities. Similarly the probands reverted to the status quo at the end of the experimental period.

Comments on methodology

The methodology of the present study merits criticism concerning the change in facility midway through, with some individuals having part of their experimental year in the Regional Poisoning Treatment Centre and part in the psychiatric hospital, whilst others had their entire time in one or other establishment. However, it will be understood that the change of venue became necessary due to the circumstances. Fortunately, in fact, it did give the advantage of studying the effect of a detoxification centre in two different settings.

The cohort enrolled for the project are not a complete random sample of alcoholic habitual drunken offenders as females were excluded because of the lack of beds available for them. It was noted that six individuals who met the criteria of previous convictions for drunkenness were not interviewed, but it is not known whether they would meet the other enrolment criteria.

The method of sampling used to recruit the cohort entailed approaching every individual appearing in court charged with a drunkenness offence, with the foreknowledge of his previous convictions, and took place on each day the court sat, spaced throughout a year. This method meant that those appearing often in court, i.e. the most recidivist offenders, had a greater chance of recruitment before the cohort was complete than those appearing say

once a year, and thus the cohort may not be a representative sample of those in the population who would meet the enrolment criteria. Nevertheless, the sample is representative of habitual drunken offenders appearing in court (and from other sources of referral) in the given period. It was noted that in both the proband and control group those with the greatest number of convictions for drunkenness in the previous year were recruited early on in the enrolment process.

Allocation of individuals to proband and control groups by random numbers resulted in groups matching well on the data obtained (see page 74).

In 56 measures it can be expected that by chance 2 or 3 may reach significance at the 5% level. Only one reached the statistical level $p<0.01$ (use of wine and crude spirits, page 90), but it has been suggested that the other 2 measures significant at $p<0.05$ are related to this (see page 90).

It is fortunate that it was the proband group which had these characteristics of being probably more severely alcoholic rather than the controls, as had the reverse been the case some of the improvement in the proband group could have been attributed to their being less severely addicted. As it is, it may be that had the groups matched even more closely there would have been measures of improvement (such as those concerning drinking habits, pages 213-217) among the probands

reaching statistical significance when compared with the controls.

Comments on reliability and validity

Reliability and validity of data obtained from alcoholics is perhaps suspect. The circumstances of the enrolment interview were often not ideal - the man befuddled with a hangover and anxious to leave the court building. However, the interviews did take place after the disposal of the case by the court when the individual had nothing to gain or lose, and he could not know whether he was likely to be a proband or control subject; the same applies to those enrolled in prison. Reliability should perhaps have been tested on a sub-sample with another interviewer. Answers given to questions in the enrolment questionnaire were in conformity with those given in the evaluation questionnaire administered one year later, and it is known that the previous convictions given by the subjects agreed with those obtained from their criminal records. The impression of the interviewer was that the men were quite open and honest in their replies.

All the interviews were conducted by the project psychiatrist or the project social worker using the same standardised questionnaire and definitions of items, and these 2 interviewers held frequent discussions to ensure they agreed on their operational criteria. However, reliability does depend in part on the individual inter-

viewer and it may be the case that the classification of type of alcoholism was made according to differing criteria.

As noted (page 79) the data on occupation and social class of the subjects, and of their fathers, would have been of more value if last and best occupations had been noted. Data obtained on subjects' age, marital status, accommodation, employment and duration of symptoms of alcoholism lead to a hypothesis that there may be two different types of 'homeless' alcoholic offenders. The first group might contain those who 'never had a chance', having had alcoholic parents or been separated from them when young. Such men never obtained skilled employment, started drinking early, remained single and never had a home of their own. The second group might contain men who started becoming alcoholic later in life, either leading to or a consequence of, for instance, break-up of their marriage, loss of job and home, and they then drifted to 'Skid Row'. To test such a hypothesis information would need to be more detailed and more accurate. It is not suggested that these two groups correspond to the constellations of inter-related phenomena described on page 100.

The classification of 'homeless' and 'home' given in Chapters 4 and 9 are arbitrary and open to criticism. Many men who had lived for many years in a common lodging

house would dispute that this was not their home and would say that they would not wish to live elsewhere. The use of such categorisation implies value judgments, as would also be the case if use had been made of 'social stability' scales. It is likely that not a few of the 'Skid Row' men could be considered socially stable within their own sub-cultures.

The separate pieces of data in Chapter 4 are of varying reliability and validity. Court appearances (page 83), which it has been noted is virtually synonymous with convictions, are those obtained from criminal records. Patients' statements of symptoms of alcoholism (page 84) are probably as reliable as in any similar studies. The answer to 'age at when first drank' (page 86) was usually given quickly as though the subject knew for certain, unless the answer was when the subject was over 20 years old. Data on circumstances of drinking and type of alcohol consumed (page 88) is of limited meaningfulness, these variables changing in individuals with the time of day and day of week. Comment has been made (page 90) that unenforced periods of abstinence by the subjects were of surprisingly long duration - the answer may be that it is only confirmed alcoholics who do strive to be abstinent and they will as a consequence remember the duration of the period. The diagnosis of type of alcoholism (page 91) is to a degree subjective, but only when the interviewer was fairly certain would he categorise an individual in a particular group. Comparison of the data obtained showed

a high degree of consensus with that of previous studies. The 'profile' of the male alcoholic habitual drunken offender in Edinburgh is that of a very sick member of society with a high degree of psychological, social and medical pathology.

Attitudes of staff

It was therefore not surprising that the difficulties and problems described in Chapter 6 arose. It is clear from the literature and from the experiences communicated by patients and colleagues, that doctors and nurses, when not trained specifically to deal with such individuals, do find it difficult to keep personal attitudes out of their professional practice. Such attitudes encountered by the project team are described in detail in Chapter 6 and it is hoped that further detoxification teams will learn from our experiences. Careful explanation of what such work entails must be given to all concerned, with ample opportunity for them to ventilate their feelings about it, especially those who will do most of the 'dirty work' - the nurses and hospital porters. Regular times must be set aside for staff to discuss their feelings and they must be encouraged to do so. In return they must be prepared to accept that some of their feelings may be related to personal attitudes which may require modification in order to achieve a 'therapeutic atmosphere' in the team. Staff working outside the detoxification centre have a heavy duty to maintain close liaison with those

inside, and report regularly on the progress of discharged patients. In some cases it will be rewarding to have patients who are doing well visit and show themselves to the hospital staff.

Staffing of detoxification centres

It seems likely that one of the problems that will face those establishing detoxification centres will be "Who is to staff the centres?". Our experience indicates that nursing staff who are psychiatrically trained and more used to handling difficult patients are more objective in their outlook and more tolerant of disturbed behaviours. The psychiatric nurses in the present project were no less efficient than medically trained nurses in management of the pathological conditions encountered. In the particular psychiatric ward in which this project was located latterly, there was no undue difficulty in managing detoxification patients and other psychiatric patients (some of whom were alcoholics being managed by a different regime) in the same ward.

Handling of detoxification patients

On the practical side it is important to make the admission procedure of a detoxification patient as easy as possible. If it is not possible for the patient to be directly admitted to the detoxification centre, it is advisable that a room be used to keep the patient at the point of entry to the hospital where he can remain separate

from other patients until he is transferred. Police officers understandably do not like to be kept waiting to hand the patient over, and there will often be occasions when drunk men will be low priority when staff are otherwise busy. Facilities for bathing patients and managing their vomit, incontinence and infestation should be readily available and in this respect hospitals have many advantages.

In some areas Alcoholics Anonymous may have much to offer a detoxification team and our system of having a member 'on call' worked well. Usefulness of AA members will depend on their competence and their own expectations of the situation. Some may be willing to help with the management of the patient on admission, others will more specifically wish to help the patient with his withdrawal symptoms.

Much can also be learned from the experience of policemen in handling drunks. We found that the attitudes of police officers were sensitive and appropriate, and their management skillful. We were impressed by the social awareness of the police at all levels of seniority and the high degree of co-operation extended to us at all times. It is not sufficient to comment "of course they would be glad to be rid of looking after the drunks". We found that the police have a genuine concern for the welfare of such people and are fully aware of the inadequacies of their management by the penal system.

The detoxification 'repeaters'

It was seen in chapter 7 that 44% of admissions for detoxification were accounted for by 10% of the patients available for admission, and 13% of those admitted at least once. It is obvious that the project team did little to help these five men with their alcoholism. In examining in detail 'known' episodes of drunkenness (police arrests or admissions for detoxification) for these individuals in the year before enrolment and for the experimental year, it is possible that three individuals were becoming drunk more often in the year following enrolment and that the provision of a detoxification facility in this respect did them a disservice. It is of course possible that these individuals would in any case have 'deteriorated' in this respect, in which case it could be considered fortunate that the detoxification facility was available.

As mentioned earlier, these 'repeaters' were always accepted for admission if referred by the police, but if repeatedly referring themselves after discharging themselves against medical advice, staff were at times allowed to use their discretion as to whether to admit or not.

Two of these individuals with multiple admissions would not fit into any rehabilitative measures outside hospital but functioned well and were happy whilst in the psychiatric ward, never seeking alcohol. However, they deteriorated rapidly on discharge and we often wished there was a long term facility available akin to the

Swedish and American labour camps mentioned on page 260.

Compulsory admission

The project team often discussed the question of compulsory admission and stay. In only two of the 337 admissions did a patient who was brought 'incapable' by the police discharge himself when the staff considered him unfit to leave as he was incapable of looking after himself, and on these occasions the police were notified by telephone (though the men were not again apprehended). We had decided that if a patient in delirium tremens tried to discharge himself we would consider detaining him under Section 31 of the Mental Health (Scotland) Act 1960, but such an occasion did not arise.

Conclusions from data on admissions

The data on days and times of admission given in Chapter 7 show that the majority of individuals were admitted between 10 a.m. and 10 p.m. and there was therefore not a need for extra night-duty staff. Routine physical examinations by a doctor were done on admission, or more fully the following morning if the patient was unco-operative on admission the previous evening. These physical examinations were necessary and did result in pathological conditions being diagnosed. As patients may be severely intoxicated, have taken an overdose of drugs as well as being drunk, have a head injury or some other condition necessitating immediate treatment, we recommend

a physical examination as soon as possible after admission. In practice this means that detoxification centres outside hospitals with medical staff 'on call' would have disadvantages.

As discussed on p. 164 we experienced difficulty in diagnosing a patient's need for detoxification. An intoxicated individual may or may not have withdrawal symptoms and withdrawal symptoms may be present in an individual who is not intoxicated. Detoxification implies management of drunkenness and any associated withdrawal symptoms, but the diagnosis is not always easy to make and further research is necessary, (and can now include the recently developed quantitative 'breathalysers').

Table 7.4 showed that in the psychiatric hospital, where the detoxification project was operated more as desired than in the RPTC, the median length of stay was 3 days, and the reasons for this have been discussed (p. 171). We conclude that this is a realistic expectation of duration of stay. However, we were often in the position of wishing that we had another place to which we could transfer men after their medical needs had been mostly met, where they could stay for another week or fortnight, whilst further assessment by doctors, social workers and others could be carried out, relieving the detoxification beds for further admissions. We recommend that whether there be one building or two, 'detoxification centres' should rather be known as 'detoxification and assessment centres', as detoxification on its own is of

limited usefulness.

Location of detoxification centres

The question of where detoxification centres should be located currently attracts much debate, but most would agree that whether the centres are 'hospital' or 'community' based, doctors, nurses and social workers will be needed. Reference has already been made in this chapter to the advantages of hospitals in the provision of facilities for the care of drunk patients. Although gastric lavage was only used once in this project, and intravenous fluids not at all, other detoxification centres would not necessarily find the same.

Of the 337 admissions, in 10 were patients comatose, in 8 a patient had taken an overdose of drugs, in 19 the patient had delirium tremens, and in 3 there were combinations of these items. In addition (see p. 166) there were 34 other instances of a doctor being called to the ward. Thus, in 73 admissions, (22%) there was an acute medical problem or a condition requiring urgent presence of a doctor on the ward. Other medical problems were dealt with by doctors on routine visits to the ward.

In addition to these medical problems on admission, patients during their stay developed pathological conditions as described on pp. 173 ff. In about 5% of admissions were these conditions of a high degree of severity, such as pneumonia, pulmonary tuberculosis, hypothermia, and deep venous thrombosis, and overall in

1 in 2 admissions there was noted an episode of 'medical morbidity' over and above intoxication and its consequences.

"Heminevrin" by mouth was the drug found to be most satisfactory in treating withdrawal symptoms, with chlorpromazine by parenteral administration. These and other drugs again can be most easily administered in a hospital environment, and we found their use was necessary in 69% of admissions.

None of the cohort died in hospital during admission for detoxification, but Chapter 8 shows that 11 of the 100 men died in a two year period. Had the entire cohort been eligible for detoxification for that two year period it is possible that some of the pathological conditions leading to their deaths may have been treated. The death rate of the group, twice the expected rate, emphasises how sick are these individuals.

There is another reason supporting our recommendation for hospital-based detoxification centres and this concerns staffing. Looking after deteriorated alcoholics is not a job that many can tolerate for long, and voluntary organisations running hostels for such men often have staff problems. Nursing staff in hospitals rotate regularly and a detoxification and assessment unit can provide opportunity for student nurses (and junior hospital doctors) to learn about problems relating to alcoholics and their management, whilst senior nursing and medical staff can provide continuity of care.

Whilst we specifically recommend hospital-based

centres, we recognise that in other areas decisions on the location may have to be pragmatic and account may have to be taken of what premises and financial support are available. It should nevertheless be borne in mind that community-based detoxification centres which depend on financial support from local rates may be less than popular with ratepayers (vide Inebriate Reformatories, p. 11).

Community services

Hostels have an essential place in the process of rehabilitation following detoxification, and the traffic from detoxification centres to hostels should not be considered 'one-way' but more of a 'roundabout', for relapses among some hostel residents are inevitable. As alcoholism is often a chronic condition characterised by relapses and remissions 'success' in treatment may be construed as the establishment of an effective system of management rather than an outcome measured only in terms of sobriety. Expertise in managing hostels for alcoholics has grown in the decade that has passed since the opening of Rathcoole House in London, due largely to the work of Timothy Cook and the Alcoholics Recovery Project.

In 'Skid Row' areas 'shopfront' centres have much to commend themselves as facilities for providing help with everyday needs.

Conclusions from data on evaluation

Chapter 9, which describes the evaluation of the effectiveness of the detoxification facility for drunken offenders, shows in tables 9.1, 9.2 and 9.3 that the proband group had a 'worse' penal record in the year before enrolment than the control subjects. This appears to be a chance finding and the explanation may be rather that the control group had an unusually 'better' year as their penal records in their year after enrolment showed a rise to figures more like those in the probands' year before enrolment. Nevertheless, it could be considered fortunate that it was the proband group which had the 'worse' penal records in the pre-experimental year.

In a project of this nature it is likely that there will be some 'rub off' of benefits on the control group and we had some evidence of this. Several magistrates knew of the existence of the project but could not usually know if any drunken offender appearing in court was a proband or not, and some magistrates seemed to think that the appropriate way of dealing with an individual was to treat them leniently and recommend they ask the detoxification psychiatrist for assistance. It is not possible to estimate the degree of effect this and other phenomena would have on the statistics given, but it is not likely to be in favour of the probands.

Tables 9.4 and 9.6 show the effect of the detoxification service on other rehabilitation facilities and it is clear that the project was effective in referring

patients for admission and that the men stayed once admitted. Whether the men benefited from these attempts at treatment and rehabilitation is another matter. It must also be stressed again that the facilities for rehabilitation of alcoholics in Edinburgh are far from adequate.

Nevertheless, we can conclude that even at the end of a year participating in the project the probands had shown definite improvement in their accommodation (pp. 217-221). Our impression, which is supported by the data on morbidity in Chapter 7, is that their physical health had markedly improved. There is no evidence one way or the other on changes in employment (pp. 221-224). Reference has been made to the difficulties encountered in estimating changes in drinking habits. However the data showed that 50% of the probands were drinking less, much less or no alcohol in the experimental year, compared with the previous year (Table 9.13), the number of days when the probands were known to be not drinking had significantly increased, and the number of known episodes of drunkenness had not increased in comparison with the control subjects. Moreover, duration of sobriety might not be the most appropriate yardstick to measure 'success' as far as the individuals are concerned: the individual probands (pp. 224-225) considered that their 'quality of life' in the experimental year had significantly improved.

Financial aspects

A question of interest to many is the cost of non-penal management of drunken offenders. Evidence from the USA shows that transfer of management to medical and rehabilitative resources can result in a saving of between 41 and 75% (Coffler & Hadley, 1973). Costing is a complex and skilled procedure but the following gives some indication of the costs in this project.

The data is artificial in the sense that time actually spent in prison and in hospital crosses financial years and only costs for the financial year 1973-74 have been used; and only hospital costs relating to the Andrew Duncan Clinic have been used in estimating hospital costs. In that financial year figures made available to the project team showed that an inmate in prison in Scotland cost about £36 per week, a patient in the Andrew Duncan Clinic cost about £76 per week and a court appearance in the District Court about £10 per appearance. These figures have been applied, for the 47 probands who completed the experimental year, to their court appearances and days in prison in the year before enrolment (for the three groups of offences) and to the same plus their days in the detoxification centre in the experimental year. The cost of further rehabilitation resources have been excluded, the data showing the cost of management of drunkenness (Table 11.1).

TABLE 11.1

Cost of Management of Drunkenness

Probands (N=47)

Year before enrolment

	for 'drunk & incapable'	for all drunkenness offences	for all offences
	£	£	£
Court appearances (from Table 9.1)	1890	2390	2740
Prison (+ police cell) (from Table 9.2)	4819	7687	12470
Detoxification	0	0	0
Total for 47 probands	6709	10077	15210
Mean per proband	143	214	324

Experimental year

	for 'drunk & incapable'	for all drunkenness offences	for all offences
	£	£	£
Court appearances (from Table 9.1)	200	570	940
Prison (+ prison cell) (from Table 9.2)	339	2083	5826
Detoxification (Text, p. 195)	11432	11432	11432
Total for 47 probands	11971	14085	18198
Mean per proband	255	300	387
Difference from year before enrolment	+£112	+£86	+£63

Table 11.1 has included the cost of a night in the police cell prior to a court appearance arbitrarily taken as the same cost as H.M. Prison. Some men may not have

been detained prior to court, having been liberated on bail, while others will have spent two nights (Saturday and Sunday) in police custody. Fines received by the court have not been included, but these will have been small. A proper cost benefit analysis would, inter alia, have to take account of social security benefits received, reduced or not received by the subjects when in hospital, prison and the community; and also in the longer term unemployment benefit and wages earned.

Table 11.1 shows that although the experimental 'detoxification' year for the probands was more expensive than the previous 'penal' year, the amounts involved were small, ranging from £63 to £112 according to the classification of offences. The middle figure £86 is perhaps the nearest estimate of the excess cost per man per year of non-penal management of drunkenness. This figure includes the cost of those men 'accidentally' prosecuted for 'drunk and incapable' and would be lower had these prosecutions not occurred. Furthermore, the few major 'repeaters' account for a large percentage of the 'detoxification' costs and it is reasonable to assume that, had more adequate facilities for their rehabilitation been available, the extra cost would be diminished further. The excess cost then is about the same cost as keeping a patient in the psychiatric hospital for about one week per year. Alternatively, had a detoxification centre been used that cost 65% of the cost of using the ADC, the costs would have broken even. As the ADC is an expensive place

to run, being an acute psychiatric admission area in a major teaching hospital, it seems reasonable to conclude that an alternative hospital setting could be found that would not be any more expensive than penal establishments.

Although the above can only be a very rough estimate being based on several unsubstantiated assumptions, it may be concluded that non-penal management of detoxification need not be a costly exercise, and experience in the USA has shown that there can be a saving of up to 75% of the costs of the penal system.

Final conclusions and recommendations

In conclusion, it is feasible to transfer the care of habitual drunken offenders from penal to medical and rehabilitative resources, the nucleus of this service being a detoxification centre, and this is desirable on humanitarian grounds and because alcoholism has been accepted as a health problem. Relieving the penal system of such men would make available considerable further facilities for management of criminals.

The effects of adding a detoxification facility to a Regional Poisoning Treatment Centre and to a psychiatric hospital have been described and discussed in detail, and we conclude that basing a detoxification centre in a psychiatric hospital is preferable to adding a detoxification service to a Regional Poisoning Treatment Centre.

We recommend that detoxification centres should be based in hospitals, with after-care being provided primarily by local authority social work departments with close co-operation with the health services. Co-ordinated networks of after-care facilities with a variety of models are necessary to meet the varying needs of individuals. Prisons should no longer be used as a means of managing alcoholic offenders but will remain necessary until detoxification centres are firmly established. In England and Wales there is now legislation providing for the non-penal management of drunken offenders and in Scotland this can probably be carried out under existing legislation.

On our evidence the provision of a detoxification facility for a group of 52 deteriorated male alcoholics had some beneficial effects in respect of improvement in their accommodation and in their drinking habits, although this was not significant when compared with the control group. It is possible that the health of the proband group had improved in view of the large amount of medical morbidity treated during admissions for detoxification, but there is no direct evidence to support this. Although the evaluation questionnaire was administered by the project workers and therefore open to criticism, it is worth recording that the subjects themselves considered there had been an improvement in the quality of their lives. Our findings must be considered in the light of this being an experimental project of

limited duration and in an area lacking proper facilities for rehabilitation of drunken offenders, and given more time and more facilities further improvement could be expected.

CHAPTER 12

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REFERENCES

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APPENDICES

Patient's Initials .....

ALCOHOLIC DETOXIFICATION – ENROLMENT FORM – CODING SHEET

CARD NUMBER 1

PROJECT IDENTIFICATION NUMBER

Col. 2 0 Experimental
1 Control

2 3 4 5

Cols. 3, 4, 5 enrolment number

DATE OF BIRTH 6 7 8 9 10 11

AGE 12 13

NATIONALITY

0 Edinburgh
1 other Scotland
2 Northern Ireland
3 Irish Republic
4 England/Wales
5 other (specify: .....)
x N/K

14

MARITAL STATUS

1 single
2 married
3 cohabiting
4 living apart
5 separated
6 divorced
7 widowed
8 other (specify : .....)
x N/K

15

CHANGE IN MARITAL STATUS

0 N/A, single
1 N/A, no change

yes, change, duration:

2 < 3 months
3 3 < 6 "
4 6 < 12 "
5 1 year < 5 years
6 5–10 years
7 11–15 "
8 16–20 "
9 over 20 years

yes, change: y duration N/K
x N/K whether change

16

ADDRESS

Edinburgh ward number:
tens in col. 17
units in col. 18

17

18

DURATION OF RESIDENCE

0 1–6 days
1 1–4 weeks
2 1 month < 3 months
3 3–6 months
4 7 months < 1 year
5 1–3 years
6 4–6 "
7 7–10 years
8 11–20 "
9 over 20 years
x N/K

19

PRESENT ACCOMMODATION: TYPE OF PREMISES

0 common lodging house
1 digs, with board
2 digs, no board
3 corporation house
4 rented house
5 owner occupied house
6 sleeping out of doors
7 hostel
8 psychiatric or other hospital
9 prison
x N/K
y other

20

PRESENT ACCOMMODATION: LIVES WITH

1 wife
2 cohabitee
3 parent(s)
4 child(ren)
5 sibling(s)
6 other relative(s)
7 friend(s)
8 alone
9 others
x N/K

21

PRESENT ACCOMMODATION: DURATION

0 less than 6 months
1 6–8 months
2 9–11 "
3 1, 2 years
4 3, 4 "
5 5, 6 "
6 7–10 "
7 11–15 "
8 16–20 "
9 over 20 years
x N/K

22

PRESENT ACCOMMODATION: LOCATION

If Edinburgh: enter ward number (tens in col. 23, units in col. 24)

23

24

If "mixed" Edinburgh, code 29

If other than Edinburgh:

Col. 23	Col. 24	
3	1	elsewhere in Midlothian
3	2	elsewhere in Scotland
3	3	England/Wales
3	4	Northern Ireland
3	5	Irish Republic
3	6	outside British Isles
3	9	"mixed" British Isles
4	1	prison
4	2	psychiatric or other hospital
y	y	other
x	x	N/K

PREVIOUS ACCOMMODATION TYPE OF PREMISES

0 common lodging-house
1 digs, with board
2 digs, no board
3 corporation house
4 rented house
5 owner occupied house
6 sleeping out of doors
7 hostel
8 psychiatric hospital or other hospital
9 prison
x N/K
y other

25

PREVIOUS ACCOMMODATION: LIVED WITH

1 wife
2 cohabitee
3 parent(s)
4 child(ren)
5 sibling(s)
6 other relative(s)
7 friend(s)
8 alone
9 others
x N/K

26

PREVIOUS ACCOMMODATION: DURATION

0 less than 5 years
1 6–10 years
2 11–15 "
3 16–20 "
4 21–25 "
5 26–30 "
6 31–40 "
7 over 40 "
x N/K

27

PREVIOUS ACCOMMODATION: LOCATION

If Edinburgh: enter ward number (tens in col. 28, units in col. 29)

28

29

If "mixed" Edinburgh code 29

If other than Edinburgh:

Col. 28	Col. 29	
3	1	elsewhere in Midlothian
3	2	elsewhere in Scotland
3	3	England/Wales
3	4	Northern Ireland
3	5	Irish Republic
3	6	outside British Isles
3	9	"mixed" British Isles
4	1	prison
4	2	psychiatric or other hospital
x	x	N/K

SOCIAL CLASS:
WRITE OCCUPATION .....

0 I
1 II
2 non-manual III
3 manual III
4 IV
5 V
6 H.M. Forces
7 other
x N/K

30

PRESENT EMPLOYMENT STATUS:

0 unemployed
1 full-time employed
2 casual/seasonal
3 retired
4 other
x N/K

31

DURATION OF PRESENT EMPLOYMENT STATUS:

0 less than 1 week
1 1–4 weeks
2 1–6 months
3 7 months < 12 months
4 1–5 years
5 6–10 "
6 11–15 "
7 16–20 "
8 21–30 "
9 over 30 years
x N/K

32

WORK PERFORMANCE IN LAST YEAR:

1 continuously employed
2 employed 9 months to 12 months
3 employed 6 months < 9 months
4 employed 3 months < 6 months
5 employed less than 3 months
6 continuously unemployed
x N/K

33

LONGEST CONTINUOUS EMPLOYMENT:

enter years, tens in col. 34,
units in col. 35
xx N/K

34
35

LONGEST CONTINUOUS UNEMPLOYMENT

enter years, tens in col. 36,
units in col. 37
xx N/K

36
37

FATHER'S SOCIAL CLASS
WRITE FATHER'S OCCUPATION.....

0 I
1 II
2 non-manual III
3 manual III
4 IV
5 V
6 H.M. Forces
7 other
x N/K

38

LAST COURT APPEARANCE (DRUNKENNESS)

Charge:

1 drunk and incapable
2 breach of the peace
3 vagrancy/begging
4 petty assault
5 damage to property/ malicious mischief
6 nuisance
7 any combination of 2 or more of above
8 other
x N/K

39

Date:

0 within 24 hours
1 1 day – 1 week
2 8 days < 1 month
3 1 month < 2 months
4 2 months < 3 "
5 3 " < 4 "
6 4 " < 5 "
7 5 " < 6 "
8 6 " < 9 "
9 9 " <12 "
x N/K

Result:

0 absolute discharge
1 conditional discharge
2 admonished
3 fine, paid or paying
4 imprisonment, by default
5 imprisonment, no option
6 bound over
7 probation
8 suspended prison sentence
9 other
x N/K

40

41

COURT APPEARANCES IN LAST YEAR

1 1
2 2
3 3–5
4 6–10
5 11–25
6 26–50
7 over 50
x number N/K

42

TOTAL COURT APPEARANCES

1 1
2 2
3 3–5
4 6–10
5 11–25
6 26–50
7 51–100
8 101–200
9 201–300
0 over 300
x number N/K

43

OTHER OFFENCES

0 none
1 1
2 2
3 3–5
4 6–10
5 over 10
y yes, number N/K
x N/K whether other offences

44

DEBTS

0 none
1 yes
2 yes, court action threatened
3 yes, court action pending
x N/K

45

PREVIOUS TREATMENT FOR ALCOHOLISM

0 none
1 psychiatric
2 other medical
3 other
4 combinations of 1, 2, 3
x N/K

46

PARASUICIDE

0 never
1 yes, admitted
2 yes, not admitted
x N/K

47

PSYCHIATRIC TREATMENT

for each code

0 never
1 yes, in past, not now
2 yes, in past, ~~not~~ and now
3 yes, at present only

in-patient 48
out-patient 49

Patient's Initials .....

ALCOHOLIC DETOXIFICATION – ENROLMENT FORM – CODING SHEET
Second (continuation) Sheet

CARD NUMBER 1 [ ]

PROJECT IDENTIFICATION NUMBER

2 3 4 5 [ ][ ][ ][ ]

DATE OF BIRTH

6 7 8 9 10 11 [ ][ ][ ][ ][ ][ ]

DRINKING HISTORY (A)

for each code 0 never
1 yes
x N/K

morning shakes	12	[ ]
amnesias	13	[ ]
fall in tolerance	14	[ ]
DT's	15	[ ]
auditory hallucinations	16	[ ]
visual hallucinations	17	[ ]
alcoholic hallucinosis	18	[ ]
withdrawal fits	19	[ ]

DRINKING HISTORY (B)
FIRST TOOK A DRINK

write age in years .....

0 14 or less
1 15
2 16
3 17
4 18
5 19
6 20
7 21–25
8 26–35
9 36–45
y 46 and over
x N/K

20 [ ]

DRINKING HISTORY (C) YEARS SINCE FIRST EXPERIENCED

for each code
0 never
1 less than 1 year
2 1, 2 years
3 3, 4 "
4 5, 6 "
5 7–9 "
6 10–13 "
7 14–19 "
8 20–29 "
9 30–39 "
y 40 and over
x N/K

first got drunk	21	[ ]
first drinking most days	22	[ ]
drink started interfering with life	23	[ ]
first lost a job through drink	24	[ ]
first drunkenness arrest	25	[ ]
first imprisonment	26	[ ]
morning shakes	27	[ ]
morning drinking	28	[ ]
amnesias	29	[ ]
DT's	30	[ ]

DRINKING HISTORY (D) WHERE :

prefers to drink

0 at home
1 in pubs
2 outside
3 anywhere
4 other
x N/K

31 [ ]

DRINKING HISTORY (E) WITH WHOM:

0 alone
1 wife/cohabitee
2 special drinking companion(s)
3 anyone
4 other
x N/K

32 [ ]

LONGEST ABSTINENCE

0 less than 1 day
1 2–4 days
2 5–6 "
3 1–2 weeks
4 3–4 "
5 1–2 months
6 3–4 "
7 5–6 "
8 7–9 "
9 over 9 months
x N/K

33 [ ]

TYPE OF ALCOHOL TAKEN

0 beer only
1 spirits only
2 wine only
3 crude spirits only
4 beer and spirits mixed
5 beer and crude spirits
6 wine and crude spirits
7 other mixed drinks
8 other
x N/K

34 [ ]

CLASSIFICATION OF ALCOHOLISM

0 psychological dependence
1 loss of control
2 inability to abstain
3 periodic bout drinker
4 other
x N/K

35 [ ]

FAMILY HISTORY OF ALCOHOLISM (A)

for each code
0 none
1 positive
y N/A
x N/K

mother 36
father 37
sibling(s) 38
child(ren) 39

FAMILY HISTORY (B)

code
0 not excessive
2 alcohol dependence, treated
3 alcohol dependence, untreated
y N/A
x N/K

wife 40
cohabitee 41

ABUSE OF DRUGS

0 never
1 yes, but not within last year
2 yes, in last year
x N/K

42

SEPARATION FROM PARENTS

for each code

0 not permanently separated before age 15
1 yes, before age 10 years
2 yes, between ages 10–15
x N/K

from mother 43
from father 44

ARE YOU AN ALCOHOLIC?

0 no
1 yes
2 other
x N/K

45

PSYCHIATRIC ILLNESS

0 none
1 depression
2 schizophrenia
3 organic psychiatric
4 psychoneurosis
5 other 46

specify 1.....
2.....
3.....
4.....
5.....

PHYSICAL COMPLICATIONS

for each code
0 never
1 yes
x N/K

gastritis 47
peptic ulcer 48
peripheral neuritis 49
organic brain disease 50
liver cirrhosis 51
injuries: physical assault 52
traffic accidents 53
industrial accidents 54
other accidents 55

REFERRAL

0 court
1 A & E, RIE
2 AA
3 GP
4 REH
5 gen. hosp. physician
6 samaritans
7 social work department
8 prison
9 other (specify: .....)
x N/K

56

This Form completed by

.....

Date .....

Patient's address for next appointmen

.....

.....

G.P's. name.....

Address .....

.....

EDINBURGH ALCOHOLIC DETOXIFICATION PROJECT

ENROLMENT FORM -- NOTES FOR CODING

Card number (col. 1) is first card 4
second (continuation) card 5

Project identification number

col. 2 after allocation
cols. 3, 4, 5 sequential enrolment number

Date of birth

cols. 6, 7 date of month
8, 9 month
10, 11 year

Age

cols. 12, 13 in years on date of enrolment

Nationality

col. 14 place of birth

Edinburgh means within boundaries of City of Edinburgh and Leith

Marital status

1 single means never married
4 married but living apart
5 legally separated
8 other includes combinations (e.g. divorced and cohabiting)

Change in marital status

If more than one change, since last change

0 no change, never married
1 no change in marital status
2-9, Y: time since breakdown of marriage or loss of wife: length of time patient has been separated or living apart (defined as existing at present, and having been in existence at least 3 months), divorced or widowed.
Y breakdown of marriage (meaning divorced, separated or living apart) or widowed, but unknown duration.
X not known whether change in marital status or not.

Present employment

The most common type of employment status in the last year.

1 full-time employed includes occupations which by their nature (e.g. contract work) may necessitate periods without working

2 casual/seasonal means those regularly being employed, the income being declared for the purposes of unemployment benefit/social security

3 retired means not having worked since reached retiring age, but if has worked income has not affected pension/social security

Duration of present employment status

Note that this may extend beyond one year if patient has, e.g. been fully employed for six years, including the last year. Same rules apply as for "present employment" and "duration of residence".

If patient does contract (etc.) work (see above), an unemployed period of six months or more breaks continuity.

Off sick but still paid does not break continuity.

Work performance in last year

Rules for continuity as above.

Longest continuous employment

The longest period of continuous employment in patient's working life. Rules for continuity as above.

Longest continuous unemployment

The longest period of continuous unemployment in patient's working life. If any casual work done in this period, see rules under "present employment".

Father's social class

See rules for (patient's) "social class".

Last court appearance (drunkenness)

Details of the last appearance in court on a charge concerned with drunkenness: either "drunk and incapable" or similar charge directly related to patient's intoxicated state, or an offence with which patient was charged owing to his behaviour at the time of and due to his drunkenness. It is an enrolment criterium that patient has been charged with a "drunkenness offence" within a year of enrolment. In "date", N/K therefore means time

not known, but believed to be within 12 months, and in "charge", "other" means a drunkenness offence (e.g. disorderliness) not listed; and N/K means there has been a court appearance and the charge is believed to be related to drunkenness, though the specific charge is not known.

Court appearances in last year

for offences directly related to drunkenness. See "last court appearance (drunkenness)". In the 12 months prior to enrolment.

Total court appearances

in patient's lifetime for drunkenness related offences.

Other offences

Number of convictions for offences not directly related to drunkenness in patient's lifetime. Include offences not listed in "last court appearance (drunkenness): charge" committed whilst intoxicated.

Debts

Current debts, including rent arrears and unpaid fines.

Previous treatment for alcoholism

1 psychiatric treatment includes in-patient and out-patient treatment, UTA or other special unit, individual or group psychotherapy, aversion therapy, antabuse and abstem.

2 other medical treatment includes GP and general hospital physicians.

3 other: includes Alcoholics Anonymous, Samaritans, minister of religion, religious and other similar agencies.

Drinking history

(b) first took a drink
first occasion when patient bought or was bought an alcoholic drink

Drinking history (c) years since first experienced

first drinking most days means at least four days per week
first imprisonment: for a drunkenness offence

Longest abstinence

Longest period of abstinence in the 12 months prior to enrolment. Exclude enforced abstinence through imprisonment, hospitalisation, etc.

Physical complications

Known either to the patient or obtained from medical records.

Gastritis diagnosed from symptoms - anorexia. nausea and vomiting.

Type of alcohol taken

The most common type or combination of drinks now being consumed. Spirits includes commercially produced whisky, gin, vodka, rum and brandy. Crude spirits refers to alcoholic preparations not intended for human consumption e.g. surgical spirits, "Bel-Air", etc.

Classification of alcoholism

Pattern of addiction. Types not clearly fitting 0-3 coded as "4 : other".

Family history of alcoholism

History of problem drinking in the family: excessive drinking outwith the cultural norm

(a) none means patient has relative with no history
(a) and (b) N/A means patient does not have this relative
(b) not excessive means if at all, is within cultural norm. "Treated" means having had medical treatment.

Abuse of drugs

Includes
a) barbiturates
b) "Mandrax"
c) other hypnotics, sedatives, tranquillizers
d) cannabis
e) LSD and other hallucinogens
f) amphetamines
g) cocaine
h) opiates and related compounds

Abuse means non-prescribed drugs or prescribed for another person.

Parasuicide

Previous parasuicidal behaviour

1, 2 whether or not with resultant hospital admission

Psychiatric treatment

Other than for alcoholism. It is an enrolment criterium that patient is not currently receiving psychiatric treatment for alcoholism.

Separation from parents

Through death, divorce, desertion, etc.

Are you an alcoholic?

Question asked: "Do you think you are an alcoholic?"

If asked to specify, supplementary question: "Do you think you have a drinking problem?"

2, other: includes qualified and other answers unable to be categorised as yes or no.

Psychiatric illness

Presence of psychiatric illness other than alcoholism. Known to the patient or obtained from other medical sources. See further section for personality. Specify sub-categories in spaces provided.
Other includes combinations of 1 to 4.

Referral

Mode of referral: the person(s) who alone, or being the last person(s) in the "chain" of referral who brought the patient to the attention of the research team.

0 "court" includes police
1 Accident and Emergency Department, Royal Infirmary, Edinburgh
2 Alcoholics Anonymous
3 General practitioner
4 Staff at Royal Edinburgh Hospital
5 General hospital physician

TO WHOM IT MAY CONCERN

EDINBURGH ALCOHOLIC DETOXIFICATION PROJECT

The following patient:

. . . . . .

date of birth . . . ./ . . . ./ . . . .

can, whenever intoxicated, be taken to the Accident and Emergency Department of Edinburgh Royal Infirmary, for admission and detoxification.

Note: This card is only applicable to the above named person

Signed Dr. . . . . .

date . . . . . .

IF THIS CARD IS FOUND PLEASE RETURN TO DR. J.R. HAMILTON, EDINBURGH ROYAL INFIRMARY

EDINBURGH ALCOHOLIC DETOXIFICATION PROJECT

The following patient . . . . . .

was found at (place) . . . . . .

at (time) . . . . . .hrs (date) . . . . . .197. . . .

and brought to the Accident and Emergency Department,
Royal Infirmary, Edinburgh

at . . . . . .hours on . . . . . .197 . . . .

by P.C. . . . . .

and received by Dr. . . . . .

EVALUATION OF ALCOHOL WITHDRAWAL STATE

BD assessment at 7 a.m. and 2 p.m. (for insomnia at 7 a.m. only).

Tick if any signs are present at time of assessment, or have been present since last assessment made.

Name: ..... Date of birth: .....

te														
ys since mission	0		1		2		3		4		5		6	
ne	0700	1400	0700	1400	0700	1400	0700	1400	0700	1400	0700	1400	0700	140
REXIA														
CHYCARDIA														
EATING														
EMOR														
ITATION														
SORIENTATION														
LLUCINATIONS														
NVULSIONS														
SOMNIA														

APPENDIX F

EDINBURGH ALCOHOLIC DETOXIFICATION PROJECT

Scheme for nursing evaluation of alcohol withdrawal state

Definition of signs to be observed.

1. Pyrexia: Temperature 99.5°F. or above.

2. Tachycardia: Pulse rate 100 per minute or above.

3. Sweating: This may vary in degree from beads of sweat being observable to constant heavy drenching sweat.

4. Tremor: Visible tremor of the fingers with the patient's arms extended.

5. Agitation: Note this is not to be confused with tremulousness or anxiety. It refers to an excessive activity which may vary from the patient being fidgety to constantly pacing up and down the ward or thrashing about in bed.

6. Disorientation: This refers to the disturbance of the patient's mental state such as he is not aware of where he is, what day it is, or has no idea whom he is speaking to. Patient's awareness of his surroundings may vary from being slightly inaccurate to being completely detached and oblivious.

7. Hallucinations: Meaning the patient is imagining he is seeing or hearing things which are not present.

8. Convulsions or fits.

9. Insomnia: This does not refer to the patient saying in the morning that he had not slept well but means that he has been observed by the night staff to have been awake during the night when he would have been expected to have been asleep.

(Dr.) J. R. Hamilton
1st April, 1974

Patient's Initials .....

EDINBURGH ALCOHOLIC DETOXIFICATION PROJECT

R.P.T.C. Admission Form

Card Number 1 [ ]

Project Identification Number 2 3 4 5 [ ][ ][ ][ ]

Date of birth 6 7 8 9 10 11 [ ][ ][ ][ ][ ][ ]

Year of admission 12 [ ] 13 [ ]

Month

1 Jan. 5 May 9 Sep.
2 Feb. 6 June 0 Oct.
3 Mar. 7 July 11 Nov.
4 Apr. 8 Aug. 12 Dec.

14 [ ]

Date 15 [ ] 16 [ ]

Day

1 Sun. 4 Wed. 7 Sat.
2 Mon. 5 Thurs.
3 Tues. 6 Fri.

17 [ ]

Time

X N/K
0 0200 – 0559
1 0600 – 0959
2 1000 – 1359
3 1400 – 1759
4 1800 – 2159
5 2200 – 0159

18 [ ]

Source of referral

0 referred self
1 casualty officer (not in RIE)
2 psychiatrist
3 G.P.
4 police
5 relative
6 AA
7 Samaritans
8 hostel warden, etc.
9 other (specify: .....)
X N/K
Y project team

19 [ ]

Previous admissions in this project:

Write number: tens in column 20, units in column 21.

XX N/K
YY yes, number N/K

20 21 [ ][ ]

Previous admissions for detoxification:

X N/K
0 None
1 yes, in this project only
2 yes, outwith this project only
3 yes, both in and outwith this project

22 [ ]

Previous admissions outwith this project

X N/K
Y yes, number N/K
0 none
1 1
2 2
3 3
4 4 or more

23 [ ]

Most recent discharge in this project

date: .....

X N/K
0 never
1 within previous 24 hours
2 1 day – 1 week
3 8 days < 1 month
4 1 < 2 months
5 2 < 3 "
6 3 < 4 "
7 4 < 5 "
8 5 < 6 "
9 6 < 9 "
Y 9 – 12 "

24 [ ]

Type of admission

0 voluntary
1 compulsory
X N/K

25 [ ]

Type of stay

0 voluntary
1 compulsory
X N/K

26 [ ]

Reason for admission

X N/K
0 not intoxicated
1 intoxicated, no other drug poisoning
2 intoxicated, with other drug poisoning
3 other

27 [ ]

Coma level

X N/K
0 0
1 I
2 II
3 III
4 IV

28 [ ]

Duration of coma

X N/K
0 never
1 < 12 hours
2 13 – 18 hours
3 19 – 24 "
4 25 – 48 "
5 49 – 72 "
6 73 – 96 "
7 97+ "

29 [ ]

Withdrawal Symptoms

for each code 0 absent
1 present
X N/K

shakes	30	
agitation	31	
insomnia	32	
miserable	33	
weakness	34	
gastric	35	
sweating	36	
flushed	37	
tachycardia	38	
muscle cramps	39	
paraesthesia	40	
dehydration	41	
confusion	42	
disorientation	43	
paranoid	44	
auditory hallucinations	45	
visual hallucinations	46	
fits	47	

Blood alcohol level (mg.) 48

1 none
2 trace – 50 mg.
3 51 – 100
4 101 – 150
5 151 – 200
6 201 – 250
7 251 – 300
8 301 – 400
9 401 and over
0 N/K whether done
Y done, result N/K
X not done

IV fluids 51

0 not used
1 saline only
2 fructose only
3 saline and fructose
4 other with saline
5 other with fructose
6 other with saline and fructose
7 other without saline or fructose
Y fluids used, type N/K
X N/K

Blood alcohol 49

time since last drink

0 < 1 hour
1 1 < 2 hours
2 2 < 3 "
3 3 < 4 "
4 4 < 6 "
5 6 < 12 "
6 12 < 18 "
7 18 < 24 "
8 24 < 48 "
9 48 hours and over
X N/K
Y N/A

Doctor called? 52

X N/K
0 no
yes, because of:
1 coma
2 vomit
3 TPR, BP
4 colour
5 aggressive
6 other reason

Gastric lavage 50

0 not done
1 done
X N/K

Length of stay 53 5

enter days

XX N/K

Date of discharge: .....

Disposal on discharge: .....

Patient's address for next appointment:

.....

.....

This form completed by: .....

Date: .....

Sedation used:

Tick as appropriate: none

paraldehyde

sodium amytal

chlorpromazine

thioridazine

prochlorperazine

promazine

haloperidol

chlormethiazole

chlordiazepoxide

diazepam

nitrazepam

propanolol

others (specify)

Write details, including dosage

duration and frequency

route of administration

Investigations	[illegible]
body weight	
ECG	
EEG	
CXR	
blood barbiturates	
plasma cortisol	
Hb	
WBC	
ESR	
blood gasses	
s. Na	
s. Cl	
s. HCO3	
s. K	
s. Mg	
b. urea	
blood pH	
s. bilirubin	
s. alk. phos.	
TT	
ZT	
total s. protein	
s. albumin	
s. alanine aminotransferase	
s. aspartate aminotransferase	
BSP	
antipyrine half life	
gamma butanol transpeptidase	
Australia antigen	
sputum C.S.	

EDINBURGH ALCOHOLIC DETOXIFICATION PROJECT

RPTC Admission Form : Notes for coding

Month : of admission
Date : of month (of admission)
Day : of week (of admission)
Time : of day (of admission)

Admission means time of entry into RIE

Source of referral

The person, or the last person in the chain, who initiated patient's admission.

0 patient referred himself direct to RIE
1 casualty officer in hospital other than RIE
2 REH doctor, or other psychiatrist
3 general practitioner
6 Alcoholics Anonymous
8 Warden or Superintendent of hostel, common lodging house, etc.

Previous admissions for detoxification

For alcohol detoxification

Previous admissions outwith this project

For alcohol detoxification

Type of admission,

Type of stay

whether voluntary or under a Mental Health Act recommendation

Reason for admission

X and 0 : if reason not known, and patient is not intoxicated, code as 0.

X : means not known whether or not intoxicated

Coma level

0 fully conscious
I drowsy but responding to vocal command
II unconscious but responding to minimal stimuli
III unconscious but reacting only to maximal painful stimuli
IV unconscious and no response whatever

Grade according to the lowest level of consciousness reached either on admission or during stay, i.e. if I on admission, but III next day, code as 3.

Withdrawal symptoms

on admission or present at any time during stay

Shakes	: shaking or tremor of the hands
Agitated	: partly describing patient's subjective state, but mostly observable. Includes : nervous, irritable, dis-attentive, fearful, alert, jumpy, easily startled; psychomotor hyperactivity, akathisia, dysphoria.
Insomnia	: sleeping badly; may be having bad, disturbing dreams or nightmares.
Miserable	: Mood state - anxious or depressed,
Weakness	: and fatigue.
Gastric	: anorexia, nausea, vomiting, retching.
Flushed	: face.
Tachycardia	: pulse rate 100 or over per minute.
Dehydration	: includes thirst.
Disorientation	: for person, place or time.
Fits	: alcohol withdrawal convulsions.

Blood alcohol

Duration between last drink and time of withdrawal of corresponding blood sample.

IV fluids

Intravenous fluids

Y fluids known to be used, type unknown.
X unknown whether or not fluids used.

Doctor called?

Whether or not nursing staff called for medical assistance between time patient admitted and time routinely seen by doctor.

1 coma : deterioration of level of consciousness
2 persistent vomiting
3 hypotension, tachycardia, etc.
4 cyanosis, etc.
5 difficult to manage, violent

Length of stay

tens in col. 52, units in col. 53
99 = 99 days or over

APPENDIX I

ALCOHOLIC DETOXICATION PROJECT

Checklist for each admission

Patient's name . . . . . .

Admission date . . . . . .

	Not done	Done	Report received	Not applicable
urine analysis				
body weight				
blood alcohol (on admission)				
blood alcohol (after 24-48 hours)				
X-ray chest and skull				
Hb, WBC, ESR				
LFT's				
VDRL				
urea, electrolytes				
ECG				
research admission form completed		yes	no	
yellow card amended		yes	no	not applicable
admission notes		yes	no	
'stay' notes		yes	no	
discharge notes		yes	no	
G.P. discharge letter		yes	no	
further appointment		yes	no	

O.E.D. ..... Patient's Initials .....

EDINBURGH ALCOHOLIC DETOXICATION PROJECT – EVALUATION FORM

ER 1

ENTIFICATION NUMBER
2 3 4 5

RTH
6 7 8 9 10 11

ATUS

ing
part
ed
d
d
specify: .....)

12

MARITAL STATUS
) none
uration
< 3 months
3 < 6 months
6 < 9 months
9-12 months
duration N/K
N/K whether change

13

ATION IN THE LAST YEAR
ses
) common lodging house, night shelter
digs, with board
digs, no board
corporation house
rented house
owner occupied house
sleeping out-of-doors
hostel
psychiatric or other hospital
prison
N/K
other

14

wife
cohabitee
parent(s)
child(ren)
sibling(s)
other relative(s)
friend(s)
alone
others
N/K

15

duration 0 < 3 months
1 3 < 6 months
2 6 < 9 months
3 9-12 months
X N/K

16

location
if Edinburgh: enter ward number
(tens in col. 17, units in col. 18)

17
18

if "mixed" Edinburgh, code 29
if other than Edinburgh:

Col. 17	Col. 18
3	1 elsewhere in Midlothian
3	2 elsewhere in Scotland
3	3 England/Wales
3	4 Northern Ireland
3	5 Irish Republic
3	6 outside British Isles
3	9 "mixed" British Isles
4	1 prison
4	2 psychiatric or other hospital
Y	Y other
X	X N/K

ACCOMMODATION IN LAST MONTH
no. days in each type of premises

common lodging house	19	20
night shelter	21	22
digs with board	23	24
digs, no board	25	26
corporation house	27	28
rented house	29	30
owner occupied house	31	32
sleeping out-of-doors	33	34
hostel	35	36
psychiatric hospital	37	38
other hospital	39	40
prison	41	42
N/K	43	44
other (specify .....)	45	46

PRESENT EMPLOYMENT STATUS:
0 unemployed
1 full-time employed
2 casual/seasonal
3 retired
4 other
X N/K

47

SOCIAL CLASS:
write occupation .....
0 I
1 II
2 non-manual III
3 manual III
4 IV
5 V
6 H.M. Forces
7 other
X N/K

48

WORK PERFORMANCE IN LAST YEAR:
1 continuously employed
2 employed 9 months to 12 months
3 employed 6 months < 9 months
4 employed 3 months < 6 months
5 employed less than 3 months
6 continuously unemployed
X N/K

49

DEBTS
0 none
1 yes
2 yes, court action threatened
3 yes, court action pending
X N/K

50

DRINKING HISTORY (A)
last month
for each code 0 never
1 yes
X N/K

morning shakes	51
amnesias	52
DT's	53
auditory hallucinations	54
visual hallucinations	55
alcoholic hallucinosis	56
withdrawal fits	57

DRINKING HISTORY (B)

last year

for each code
0 better
1 the same
2 worse
Y N/A
X N/K

morning shakes 58

amnesias 59

DT's 60

tolerance 61

drinking most days 62

drink interfering with life 63

morning drinking 64

DRINKING HISTORY (C) where:

prefers to drink
0 at home
1 in pubs
2 outside
3 anywhere
4 other
X N/K

65

DRINKING HISTORY (D) with whom:

0 alone
1 wife/cohabitee
2 special drinking companion(s)
3 anyone
4 other
X N/K

66

LONGEST ABSTINENCE

0 less than 1 day
1 2-4 days
2 5-6 days
3 1-2 weeks
4 3-4 weeks
5 1-2 months
6 3-4 months
7 5-6 months
8 7-9 months
9 over 9 months
X N/K

67

TYPE OF ALCOHOL TAKEN

0 beer only
1 spirits only
2 wine only
3 crude spirits only
4 beer and spirits mixed
5 beer and crude spirits
6 wine and crude spirits
7 other mixed drinks
8 other
X N/K

68

CLASSIFICATION OF ALCOHOLISM

0 psychological dependence
1 loss of control
2 inability to abstain
3 periodic bout drinker
4 other
X N/K

69

ABUSE OF DRUGS

0 never
1 yes, but not within last year
2 yes, in last year
X N/K

70

ARE YOU AN ALCOHOLIC?

0 no
1 yes
2 other
X N/K

71

AMOUNT OF DRINK

on the whole are you drinking, compared with a year ago,

1 much more
2 more
3 the same
4 less
5 much less
0 none
X N/K

72

QUALITY OF LIFE

Do you feel your life has improved in the last year?

0 better
1 the same
2 worse
3 other
X N/K
Y N/A

73

COURT APPEARANCES

outside Edinburgh in the last year

write details: date, court, charge, result
include dates of all terms in prison

ADMISSIONS TO HOSPITAL

in last year

(including those for detoxication)

excluding all project admissions

write details including name of h
reason for admission, dates

Patient's address for next co

.....

.....

This form completed by:

.....

Date: .....

Patient's Initials .....

EDINBURGH ALCOHOLIC DETOXIFICATION PROJECT

DRUNKEN OFFENDER SURVEY : QUESTIONNAIRE AND CODING SHEET

Number 1 | 6

ct Identification Number

.. 2 2 Male
3 Female 2 3 4

.. 3, 4 enrolment number

of
h

5 6

nality

Edinburgh
other Scotland
Northern Ireland
Irish Republic
England/Wales
other (specify: .....)
N/K

7

al Status

single
married
cohabiting
living apart
separated
divorced
widowed
other (specify: .....)
N/K

8

Present Accommodation:
Location
Write address .....

.....

Coding:
If Edinburgh: enter ward number
(tens in col. 9 units in col. 10)

9
10

If "mixed" Edinburgh, code 29
If other than Edinburgh:

Col. 9	Col. 10	
3	1	elsewhere in Midlothian
3	2	elsewhere in Scotland
3	3	England/Wales
3	4	Northern Ireland
3	5	Irish Republic
3	6	outside British Isles
3	9	"mixed" British Isles
4	1	prison
4	2	psychiatric or other hospital
y	y	other
x	x	N/K

Present Accommodation:
Type of premises
0 common lodging house or night shelter
1 digs, no board
3 corporation house
4 rented house
5 owner occupied house
6 sleeping out of doors
7 hostel
8 psychiatric or other hospital
9 prison
x N/K
y other

11

Present Accommodation:
Lives with
1 wife or husband
2 cohabitee
3 parent(s)
4 child(ren)
5 sibling(s)
6 other relative(s)
7 friend(s)
8 alone
9 others
x N/K

12

Present Accommodation:
Duration
0 less than 6 months
1 6 - 8 months
2 9 - 11 "
3 1, 2 years
4 3, 4 "
5 5, 6 "
6 7 - 10 years
7 11 - 15 "
8 16 - 20 "
9 over 20 years
x N/K

13

Social Class:
Write occupation .....

If housewife, write husband's occupation

0 I
1 II
2 non-manual III
3 manual III
4 IV
5 V
6 H.M. Forces
7 other
x N/K

14

Present Employment Status:
0 unemployed
1 full-time employed
2 casual/seasonal
3 retired
4 housewife
5 other
x N/K

15

Work Performance in last year:
1 continuously employed
2 employed 9 months to 12 months
3 employed 6 months < 9 months
4 employed 3 months < 6 months
5 employed less than 3 months
6 continuously unemployed
7 housewife
8 retired
x N/K

16

r's Social Class
father's occupation:

.....

I
II
non-manual III
manual III
IV
V
H.M. Forces
other
N/K

17

ere you drinking yesterday (or day
ted)?
te .....
.....

e have different feelings about
mount they would like to drink.
of these statements comes
st to the way you feel?
I wish I could drink more than
I do
I'm perfectly satisfied with the
amount I drink now
I sometimes feel I should drink
less than I do now
I would definitely like to cut
down the amount I drink
other response

18

you ever tried to CUT DOWN your
king?
yes
no
other (specify):
.....

19

you ever a HEAVIER DRINKER than
are now?
no
slightly heavier
much heavier
not sure
no answer

20

ng the last 12 months how often
you had a drink?
never
everyday
most days
weekends only
(or) once or twice a week
once or twice a month
once or twice in 6 months
once or twice a year
(or) special celebrations only
don't know
no answer

DRINKING HISTORY (A)
for each code
0 no
1 yes
2 other
3 N/K

Have you ever had difficulties at work because of drinking?

22

Has your doctor ever advised you not to drink as much as you do?

23

Have you ever had trouble or quarrels with family or friends because of your drinking?

24

Have you ever had financial problems because of your drinking?

25

Have you ever gone without a drink for a period to prove you can do so?

26

Do you ever find when you start drinking you can't stop?

27

Longest Abstinence
0 less than 1 day
1 2 - 4 days
2 5 - 6 "
3 1 - 2 weeks
4 3 - 4 "
5 1 - 2 months
6 3 - 4 "
7 5 - 6 "
8 7 - 9 "
9 over 9 months
x N/K

28

Type of Alcohol taken
0 beer only
1 spirits only
2 wine only
3 crude spirits only
4 beer and spirits mixed
5 beer and crude spirits
6 wine and crude spirits
7 other mixed drinks
8 other
x N/K

29

When drinking what is the USUAL AMOUNT of these that you drink?

beer .....

spirits .....

wines .....

others .....

DRINKING HISTORY (B)
for each code 0 never
1 yes
x N/K

morning shakes	30
amnesias	31
fall in tolerance	32
DT's	33
morning drinking	34
withdrawal fits	35

DRINKING HISTORY (C)
First took a drink

write age in years .....
0 14 or less
1 15
2 16
3 17
4 18
5 19
6 20
7 21 - 25
8 26 - 35
9 36 - 45
y 46 and over
x N/K

36

rs since first experienced
or each code 0 never
1 less than 1 year
2 1, 2 years
3 3, 4 "
4 5, 6 "
5 7 - 9 "
6 10 - 13 years
7 14 - 19 "
8 20 - 29 "
9 30 - 39 "
y 40 and over
x N/K

irst got drunk 37

irst drinking most days 38

rink started interfering ith life 39

irst lost a job through rink 40

irst drunkenness arrest 41

irst imprisonment 42

sical Complications
or each code 0 never
1 yes
x N/K

astritis or peptic ulcer 43

njuries: physical ssault 44

raffic accidents 45

se of drugs
never
yes, but not within last year
yes, in last year
N/K
46

vious treatment for alcoholism
none
psychiatric
other medical
other
combinations of 1, 2, 3
N/K
47

chiatric treatment
or each code
never
yes, in past, not now
yes, in past and now
yes, at present only
in-patient 48

Parasuicide
0 never
1 yes, admitted
2 yes, not admitted
x N/K
50

Are you an alcoholic?
0 no
1 yes
2 other
x N/K
51

If you think you have a drinking problem, do you wish help with it?
0 don't have drinking problem
1 no
2 yes
3 getting help already
4 don't know
5 other (specify .....)
52

Would you have been willing to have come into hospital for sobering up or drying out when you were arrested?
0 no
1 yes
2 don't know
3 other (specify .....)
53

Spontaneously complained of problems
Will you tell me of any problems yo have just now?

Write:

code for each
0 no
1 yes
2 N/K
domicile 54

work 55

money 56

clothes 57

drink 58

'nerves' 59

physical ailments 60

interpersonal 61

other 62

This form completed by

.....

Date .....

Last court appearance
(drunkenness)
Charge:
1 drunk and incapable
2 breach of the peace
3 vagrancy/begging
6 nuisance
7 any combination of 2 or more of above
8 other
x N/K

63

Date:
0 within 24 hours
1 1 day - 1 week
2 8 days < 1 month
3 1 month < 2 months
4 2 months < 3 "
5 3 " < 4 "
6 4 " < 5 "
7 5 " < 6 "
8 6 " < 9 "
9 9 " < 12 "
x N/K

64

Result:
2 admonished
3 fine, paid or paying
4 imprisonment, by default
5 imprisonment, no option
9 other
x N/K

65

Court appearances in last year
1 1
2 2
3 3 - 5
4 6 - 10
5 11 - 25
6 26 - 50
7 over 50
x number N/K

66

Total court appearances
1 1
2 2
3 3 - 5
4 6 - 10
5 11 - 25
6 26 - 50
7 51 - 100
8 101 - 200
9 201 - 300
0 over 300
x number N/K

67

Other offences
0 none
1 1
2 2
3 3 - 5
4 6 - 10
5 over 10
y yes, number N/K
x N/K whether other offendes

68

EDINBURGH ALCOHOLIC DETOXIFICATION PROJECT

DRUNKEN OFFENDER SURVEY

Definitions and Notes for Coding

Age

cols. 5, 6 in years on date of enrolment.

Nationality

col. 7 place of birth; Edinburgh means within boundaries of City of Edinburgh and Leith.

Marital status

code 1 single means never married
4 married but living apart
5 legally separated
8 other includes combinations (e.g. divorced and cohabiting)

Present accommodation

The most common type of living situation in the past year

Type of premises

0 common lodging house, similar hostel or dormitory
1,2 digs means rented room(s)
1 board provided
2 provides own board
7 hostel excluding common lodging houses

Lives with

Code for person highest in hierarchy i.e. if lives with wife and child code 1, if with father and brother code 3.

Social class

Give that according to usual occupation.
If retired or unemployed, write previous occupation (i.e. last job).
If casual or seasonal, write occupation as that of best job ever.
If housewife, write husband's occupation.

Previous employment/

Present employment

The most common type of employment status in the last year.

1 full-time employed includes occupations which by their nature (e.g. contract work) may necessitate periods without working.
2 casual/seasonal means those regularly being employed, the income being declared for the purposes of unemployment benefit/social security.
3 retired means not having worked since reached retiring age, but if has worked income has not affected pension/social security.
4 non-working housewife.

Father's social class

See rules for (patient's) "social class".

Longest abstinence

Longest period of abstinence in the 12 months prior to enrolment. Exclude enforced abstinence through imprisonment, hospitalisation, etc.

Type of alcohol taken

The most common type or combination of drinks now being consumed. Spirits include commercially produced whisky, gin, vodka, rum and brandy. Crude spirits refers to alcoholic preparations not intended for human consumption e.g. surgical spirits, "Bel-Air", etc.

Drinking history

Morning shakes: hands trembling after been drinking.
Amnesias: memory gaps when been drinking; can't remember how got home, maybe wake up in strange place not knowing how got there.
Fall in tolerance: can't hold drink as well as used to, gets drunk quicker.
Morning drinking: has a drink in the morning; often before pubs open; to steady oneself up; to get rid of hangover or the shakes.
Withdrawal fits: ever had a fit when stopped drinking.

Drinking history

First took a drink
First occasion when patient bought or was bought an alcoholic drink.

Drinking history/

Drinking history

Years since first experienced
First drinking most days means at least four days per week.
First imprisonment: for a drunkenness offence.

Physical complications

Gastritis means stomach trouble - off food, nausea and vomiting.

Abuse of drugs

Includes
a) barbiturates
b) "Mandrax"
c) other hypnotics, sedatives, tranquillizers
d) cannabis
e) LSD and other hallucinogens
f) amphetamines
g) cocaine
h) opiates and related compounds

Abuse means non-prescribed drugs or prescribed for another person.

Previous treatment for alcoholism

Code 1 Psychiatric treatment includes in-patient and out-patient treatment, UTA or other special unit, individual or group psychotherapy, aversion therapy, antabuse and abstem.
Code 2 Other medical treatment includes GP and general hospital physicians.
Code 3 Other: includes Alcoholics Anonymous, Samaritans, minister of religion, religious and other similar agencies.

Psychiatric treatment

Other than for alcoholism.

Parasuicide

Previous attempted suicide
Code 1, 2 Whether or not with resultant hospital admission.

Are you an alcoholic?

Question asked: "Do you think you are an alcoholic?"
If asked to specify, supplementary question: "Do you think you have a drinking problem?"
2, other: includes qualified and other answers unable to be categorised as yes or no.

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Detoxication of Alcoholics: A Preliminary Report

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Background

The term 'revolving door' has been accepted as the outcome of management of drunken offenders by the penal system. Increasing realization of the ineffectiveness of attempting to deal with public drunks by the courts and prison led to Parliament in 1967 passing legislation to remove the penalty of imprisonment for drunkenness offences, but this Act will not be implemented until the Home Secretary is satisfied as to the availability of suitable accommodation for the care and treatment of drunken offenders. The Home Office (1971) Working Party on Habitual Drunken Offenders recommended the establishment of detoxification, or more properly, detoxication centres. A Scottish Home and Health Department (1965) report has suggested that the acute effects of alcoholism could best be treated by the general physician along with other forms of poisoning in a special poisons unit. The Regional Poisoning Treatment Centre in Edinburgh is well-established and has considerable staff expertise in treating poisoned patients (Matthew *et al.* 1969). It is situated in the Royal Infirmary in close proximity to the police headquarters and the Grassmarket area of the city, sometimes called Edinburgh's 'Skid Row'.

The present research project has two main objectives: to assess the feasibility of adding a detoxication facility to the Poisoning Treatment Centre; and to evaluate the effectiveness of this treatment for drunken offenders.

Enrolment

Starting in January 1973, 100 patients were enrolled over the course of the following year. The criteria for enrolment for a patient were that he was male, lived in Edinburgh, suffered from alcoholism as defined by the World Health Organization (1952), and had had at least one conviction for a drunkenness offence within the preceding year.

From each patient information was elicited concerning his social, medical and drinking history by means of a questionnaire which was designed to demonstrate any changes in his marital status, accommodation and employment. All patients were enrolled when sober. Most were recruited after an appearance for a drunkenness offence at the Burgh Court or from prison to which they had been sent, usually in default of payment of a fine.

On completion of enrolment each patient was then allocated at random to a proband or control group. The control group received no treatment other than that which they could obtain for themselves from existing facilities. Their progress was ascertained in periodic contact with project workers.

The proband group were informed as to the nature of the project and encouraged to visit the team workers for help with their problems. The full-time project workers are a psychiatrist and a social worker. The probands were issued with a card entitling them to use the detoxication unit when required. Their names were added to a list kept in the police headquarters and in the Royal Infirmary. The police authorities had intimated their support of the project and had agreed that rather than charge any proband for being 'drunk and incapable', the patient would instead be brought directly to the detoxication

unit. Police representatives attended staff meetings and their cooperation was greatly appreciated.

Admission Procedure

The admission procedure for a patient found intoxicated, or referring himself for assistance in withdrawal from alcohol, was for him first to pass through the hospital's Accident and Emergency Department where a casualty officer would ensure the absence of other physical disease. The patient would then be transferred to the Poisoning Treatment Centre. Sedation was given when indicated, the necessity being judged by the nursing staff who would monitor withdrawal symptoms using a specially-designed form.

Results

The results presented are for the first 25 patients in each of the proband and control groups to have completed 100 days since enrolment.

In the proband group the age range was from 28 to 67 with a mean of 49 years; in the controls, the range was from 27 to 71 with a mean of 47 years. Two-thirds of all the subjects were in the age group 36 to 55.

The majority of patients were born in Edinburgh or elsewhere in Scotland, the exception being 8 from the Irish Republic and one East European. There were no significant differences between the proband and control groups in nationality or in marital status. Just over half the patients in each group were single. There were 2 married and 2 widowed in each group, and the remainder, 26%, were divorced, separated or living apart from their wives.

One patient was removed from the programme after 22 days as he was unable to cooperate with the aims of the project. One proband died in a night shelter after 39 days and one control after 65 days. These three subjects are not included in the results which follow.

Admission Data

In the period under study there were 63 admissions for detoxication among the 25 probands. In all but 3 admissions the patients were considered intoxicated, and in 2 cases there was poisoning by another drug in addition to alcohol. In all but 5 cases patients were fully conscious though usually confused and disorientated. In these 5 cases, 3 were Grade III unconscious, the others Grades I and II (Matthew & Lawson 1970). All recovered full consciousness within twelve hours. All admissions were voluntary though on several occasions patients discharged themselves early against medical advice.

Blood alcohol levels were not estimated routinely, but of those that were, the range on admission was from 240 to 420 mg/100 ml. On no occasion was gastric lavage or intravenous fluid required. The presence of various withdrawal symptoms was noted on each admission, but the accuracy of these recordings is open to question. In 11 of the 63 admissions the patients were thought to have no withdrawal symptoms. In only 2 admissions were frank delirium tremens present, though this low figure may be a reflection on the short mean duration of stay.

The sedation routinely used was parenteral or oral chlorpromazine. The nursing staff did not consider sedation necessary in 29 admissions (46%).

Friday and Saturday were the most popular days for admission with Sunday under-represented. Most admissions took place between 2 p.m. and 2 a.m. Admissions initiated by the police were twice as common as self-referrals.

Fourteen of the 25 probands were admitted on at least one occasion in their first 100 days. Three patients accounted for half of all admissions, one patient alone accounting for almost a quarter of the total.

Duration of Stay

The 63 admissions involved 141 days in the detoxication unit, an overall mean of 2.2 days per

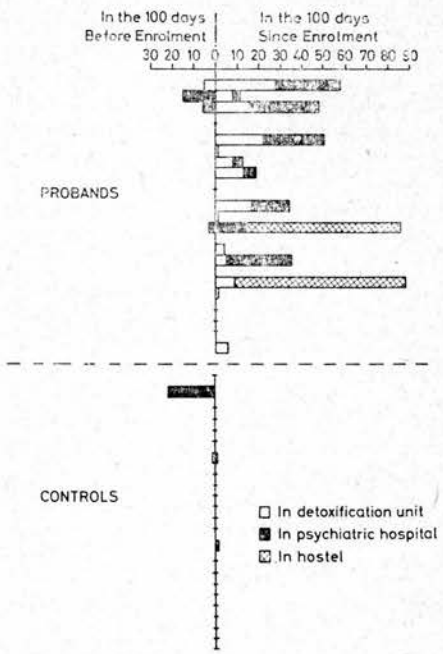

Fig 1 *Number of days 'in care'*

admission; the range was from 1 to 10 days. The median and mode were one day. The length of stay was determined by a number of variables, concerning the staff, the ward and the patients, the main one of which was intended to be the presence of withdrawal symptoms. In some instances patients may have been discharged before symptoms of withdrawal became objectively evident. In general those doing well or doing rather badly had the shorter length of stay.

Further Progress

The subsequent attempts at rehabilitation also made by the project team are depicted in Fig 1 which shows that very few of the probands or controls had had any contact with services providing care in the 100 days before enrolment, and this situation continued for the controls after their enrolment. Of the proband patients, however, 9 received treatment in psychiatric hospital, and 2 had long stays in a hostel.

Court and Prison Data

Subjects on enrolment were asked for details of their previous court appearances and terms in prison; there were no significant differences between probands and controls. About half of each group had been in court between 11 and 50 times for drunkenness offences. In each group about one-quarter had had 10 or less, and one-quarter over 50 appearances. The range was from 3 to 168.

In the year before enrolment the proband group had a slightly worse record than the controls (Table 1).

The commonest type of offence with which habitual drunken offenders in Edinburgh are charged is 'drunk and incapable'. In this study other minor offences such as 'vagrancy' or 'begging' are included as 'other drunkenness offences' as they are considered to be directly due to the patient's alcoholism, the nature of the charge reflecting the individual's circumstances at the moment of his apprehension. Separately classified are 'non-drunkenness offences' such as assault or theft.

A comparison of the number of court appearances for 'drunk and incapable' offences (Table 2) shows that in the 100 days before enrolment the control group increased by 9% from 32 to 35 appearances; the probands fell 88% from 42 to 5. This result is very highly significant.

For all drunkenness offences (Table 3) the controls fell 10% from 51 to 46 whilst the probands fell 69% from 58 to 18 court appearances. This result is highly significant.

A comparison of court appearances for all types of offence (Table 4) shows a fall in the probands compared with the controls significant at the 5% level.

There are several variables to consider when examining the number of days in prison as opposed to court appearances, not least the individual magistrate in front of whom the offender appears. However, in the period under study no proband spent any time in prison for being 'drunk and incapable' compared with 216

Table 1

Number of court appearances in the year before enrolment ($n=25$)

	Probands	*Controls*
Drunk and incapable	100	72
Breach of the peace	22	38
Other drunkenness offences	13	6
All drunkenness offences	135	116
Nondrunkenness offences	27	24
All offences	162	140

Table 2

Number of court appearances for 'drunk and incapable' offences ($n=25$)

	In the 100 days before enrolment	*In the 100 days since enrolment*	*Percentage change*
Probands	42	5	−88
Controls	32	35	+ 9

$\chi^2=19.20$; df $=1$; $P<0.0005$

Table 3

Number of court appearances for all 'drunkenness' offences ($n=25$)

	In the 100 days before enrolment	*In the 100 days since enrolment*	*Percentage change*
Probands	58	18	−69
Controls	51	46	−10

$\chi^2=9.30$; df $=1$; $P<0.005$

Table 4

Number of court appearances for all offences ($n=25$)

	In the 100 days before enrolment	*In the 100 days since enrolment*	*Percentage change*
Probands	62	27	−56
Controls	57	49	−14

$\chi^2=4.48$; df $=1$; $P<0.05$

Table 5

Number of days in prison for 'drunk and incapable' offences ($n=25$)

	In the 100 days before enrolment	*In the 100 days since enrolment*	*Percentage change*
Probands	216	0	−100
Controls	128	127	− < 1

days in the 100 days before enrolment (Table 5). In the same periods the control group fell less than 1% from 128 to 127 days. There was also a very highly significant fall in days in prison for all drunkenness offences.

Summary

The detoxication project in its first 100 days for each proband has resulted in 63 admissions for detoxication. No proband has been in prison for being 'drunk and incapable' since enrolment and court appearances for this and other drunkenness offences have been substantially reduced. Moreover the amount of time spent in psychiatric hospital or in a hostel has been markedly increased. The 216 days spent in prison for being 'drunk and incapable' in their 100 days before enrolment has been replaced by 460 days in hospital or hostel in the 100 days since enrolment.

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